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INDIAN HEALTH ISSUES BILLINGS, MONT.

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

INDIAN HEALTH ISSUES

JULY 8, 1983
BILLINGS, MONT.

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INDIAN HEALTH ISSUES
BILLINGS, MONT.

JULY 8, 1983

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in the Granite Room, Sheraton Hotel, Billings, Mont., Senator John Melcher (acting chairman) presiding.

Present: Senator Melcher.

Staff present: Max Richtman, minority staff director.

Senator MELCHER. The hearing will come to order.

My friends and fellow workers for Indian Health, we meet today on this most basic of all pressing issues between the United States and the tribes: the question of health. What we are attempting to do today is to start the process for renewal of the Indian Health Care Improvement Act which was first enacted in 1976. It was amended in 1980, and it comes up for reauthorization in fiscal year 1985.

What this means is that it is essential that we reenact this piece of legislation, reauthorize it this calendar year, so that there will be no question when the people who start working on the budget for fiscal year 1985, within the administration, will take this act into account in all their budget preparations.

When we were considering the amendments to the Indian Health Care Improvement Act, we held a hearing here in Billings—I believe it was in 1978, possibly the end of 1977—to receive testimony from the people who deal with Indian health, and the people who make it their concern on behalf of the tribes to work for them all year round, year after year.

Out of that, we thought we had some good amendments. But we are not satisfied at all that we have reached the Utopia of having a real fine, functional law for Indian Health Service, a guide to them to provide what is absolutely essential for Indian families all the way from preventive health, through clinic care, hospitalization, and care for the elderly. So, we are hopeful today that the testimony we receive will be helpful and instructional to improve the act.

I will start this process, of course, right here with the grassroots and we will hear from tribes in this area. We will take note of constructive suggestions you make, and particularly note the existing problems. We know there are plenty of existing problems.

If we are to succeed with a good health program for Indian people, we are going to have to start where Indian people start. We are going to have to start with the very young. We are going to have to have a

system that is comprehensive and effective for the community health representatives. If CHR's are not going to be funded, what is going to take their place? And, if CHR's are going to be limited and held back, where are we really making any headway? That is the first point.

We have to have people who are dedicated, knowledgeable, and accepted by Indian families on the reservations to be able to provide advice and preventive health care, the first diagnostic step for treating the sick patient.

We move then to the clinics and to the hospitals. We have noted for 10 years a problem that has existed, and it is yet to be corrected, where there are funds available at the higher level, but yet not available for sick people. We have to correct that. I think we can. We want your suggestions on it.

We have not had much money, as you know, to hire as many doctors or nurses as we would like to have. But, we are not convinced—that is, the Select Committee on Indian Affairs in the Senate is not convinced—that some of the money that is used at the higher levels in IHS cannot be used at lower levels where patients are, where the people are.

We have not been able to build much in the way of hospitals. And, we have had to contemplate the idea that there will be contract services for hospitals. Competitive bidding for contract services, patterned after the Department of Defense, simply is not practical in Indian country where we have distances that must be considered for transportation of the sick patients, and also for their families to be able to visit them. That also has to be considered.

So, we look with a great deal of concern on any contract that is entered into with the hospital to make sure it fits the area and fits the circumstances. I think we have had some evidence of a degree of cooperation from Indian Health Service officials on that point.

Well, there is a lot of work to be done, and this is going to be a long hearing. Witnesses are limited to no more than 10 minutes, and I hope a lot of you can summarize your statement in 5 minutes.

All of the testimony will be made a part of the record and we will review it and it will be very helpful for us. But, if we let the hearing drag out too long, we will not get in all the witnesses, and that is important. The 10 minutes will include asking questions so that we can be certain that we have a good understanding of the testimony, and also have some time to review with Indian Health Service people the points that are raised at this hearing. I believe the Indian Health Service people themselves will be our last witnesses.

We are going to call the witnesses separately. First up will be John Windy Boy, chairman of the Chippewa-Cree Business Committee of Box Elder.

John needs to be first. I think he has an airplane to catch and he will not tell me where he is going.

STATEMENT OF JOHN WINDY BOY, CHAIRMAN, CHIPPEWA-CREE TRIBE, ROCKY BOY RESERVATION, BOX ELDER, MONT.

Mr. WINDY BOY. Mr. Chairman, my name is John Windy Boy, and I am the chairman of the Chippewa-Cree Tribe of the Rocky Boy Reservation. On behalf of the Chippewa-Cree business committee,

tribal members and American Indians across the United States, I wish to express my appreciation to the Senate Select Committee on Indian Affairs for taking this time to receive testimony from those of us who are concerned about the current health care issues facing my people: the American Indian.

As you may know, efforts to curtail services have been already implemented. The health care budgets have already been reduced. Plans for further reductions are already in progress.

With these facts in mind, I must clearly impress upon you to recognize the American Indian. Make your recommendations to Congress to stand up for my people, to recognize the accomplishments and achievements we have made in the area of health, and to realize these accomplishments and achievements were made only through laws such as the Snyder Act, the Indian Self-Determination Act and the Indian Health Care Improvement Act.

My testimony is written and will be submitted to appropriate people. I am testifying on behalf of the Chippewa-Cree Tribe. I have completed a careful study of the health issues and have identified one single element we need to keep in mind. That is the importance of health to an individual and to a total community.

I have identified nine categories I am addressing in my written statement. These nine categories I am sure are not inclusive, but each one reflects a need for improved health services to American Indians.

The categories I outlined are:

1. The Indian Health Care Improvement Act Reauthorization.
2. Existing inadequacies in health manpower, material and facilities.
3. The impact of budget cuts to IHS.
4. Unmet needs for water and sanitation facilities.
5. Competitive bidding on health care contracts.
6. Problems related to the 638 contracting process.
7. The functions and values of the CHR program.
8. Elevation of the director of IHS.
9. Response to the CHS Task Force report.

And I urge you to do as I did. Study the categories with the major thought in mind being the individual's health. Do not put a dollar figure on the health of any individual. Not when millions and billions are spent for the military and other countries and other programs.

In comparing the health status of American Indians, we have come a long way from the days we camped by army posts, but we have not come far enough. We are still behind the general population. Our life span is still shorter than the non-Indian. Alcoholism, suicide, accidents, and other devastating conditions are still higher than the non-Indian.

I could talk all morning on the need for funds, services, programs, and facilities needed by my people. I am sure you have heard much of that before.

In further discussion of eligibility, CHS guidelines specifying eligibility of spouses who come from the same tribe but another country—Canada—affects a major population on the Rocky Boy Reservation.

Guidelines require proof of descendency which should be without question for Cree people from Canada who are married into the Chippewa-Cree Tribe at Rocky Boy.

We recommend that the Cree people be given the same leeway as the Blackfeet and Mohawks based on the stipulation of the Jay Treaty between the U.S. and Canada. Another basis would be the close interrelationship between the Cree of Canada and the Cree of Rocky Boy.

I just want you to take my written testimony and make sure people in D.C. know our concerns and remember the American Indian is one of the truly needy in this country. Thank you for your concern.

If there are some questions, I would be happy to answer them. Like I said, I could talk all morning.

Senator MELCHER. All right. Thank you, John. All of that will be made part of the record along with your oral testimony. This letter, dated April 25, from you will be made part of the record along with your prepared statement.

Now, you had a problem with needing another doctor to operate the emergency facilities. Is that doctor in place now or not?

Mr. WINDY BOY. We understand there is one coming.

Senator MELCHER. But not yet there?

Mr. WINDY BOY. Not yet.

Senator MELCHER. Have you been notified of the date he is to arrive?

Mr. WINDY BOY. I was notified that there was one coming but no date.

Senator MELCHER. Are the emergency facilities still open?

Mr. WINDY BOY. Yes, sir.

Senator MELCHER. You will keep them open until he gets there, is that it?

Mr. WINDY BOY. Yes.

Senator MELCHER. Now, the records we have here for Rocky Boy show that the number of people treated for upper respiratory infections is by far the greatest. And there is still one active case of TB yet on the Rocky Boy? Are you familiar with that?

Mr. WINDY BOY. Yes.

Senator MELCHER. The record shows that pneumonia and influenza are also high on this list. This list is supplied by IHS. If you have the emergency facilities open as it has been in the past, and if you get this additional doctor, do you believe that the service will be improved, that it is making some headway?

Mr. WINDY BOY. Right.

Senator MELCHER. Do you believe it is?

Mr. WINDY BOY. So far we will have to wait and see what is going to happen. Like I said, we were told a doctor is coming. I do not know when.

Senator MELCHER. We will find that out. We will get a date for his arrival.

Do the patients that must be hospitalized from Rocky Boy go to Havre?

Mr. WINDY BOY. Yes.

Senator MELCHER. Which is about 55 or 58 miles?

Mr. WINDY BOY. It is 60 miles, round trip.

Senator MELCHER. Oh, that is round trip? It is 30 miles one way.

Mr. WINDY BOY. Yes.

Senator MELCHER. Have you been given pretty good treatment at that hospital?

Mr. WINDY BOY. Yes.
Senator MELCHER. No problems there?
Mr. WINDY BOY. No.
Senator MELCHER. Do you have community health representatives?
Mr. WINDY BOY. Yes.
Senator MELCHER. How many?
Mr. WINDY BOY. About eight.
Senator MELCHER. Do you consider that number adequate?
Mr. WINDY BOY. We could use some more.
Senator MELCHER. Do they use their own vehicles?
Mr. WINDY BOY. Yes.
Senator MELCHER. Is there enough mileage money allowed?
Mr. WINDY BOY. No.
Senator MELCHER. There is not? That is set at only so much?
Mr. WINDY BOY. Yes.
Senator MELCHER. What has been your experience, John, in the elderly population? Is there a growing need for medical treatment for the elderly?
Mr. WINDY BOY. Yes.
Senator MELCHER. Are they reluctant to go to the hospital?
Mr. WINDY BOY. Yes; some are.
Senator MELCHER. How many beds do you have in the emergency facility there?
Mr. WINDY BOY. We do not have any.
Senator MELCHER. No beds at all?
Mr. WINDY BOY. No.
Senator MELCHER. They cannot keep a patient overnight?
Mr. WINDY BOY. No.
Senator MELCHER. Is part of the problem with the reluctance of the elderly to go to the hospital in Havre?
Mr. WINDY BOY. Partly, yes.
Senator MELCHER. They want to be sure to stay at home?
Mr. WINDY BOY. Yes.
Senator MELCHER. I think you made it clear in your testimony that you are opposed to having the sick Indian patient pay the bill and then apply to get it back? Would that inhibit a patient from coming in for treatment?
Mr. WINDY BOY. They would be scared when it comes to the claim, because——
Senator MELCHER. They would be scared to? Wonder if they would ever get the money back? Some of them wonder where they would get the money to begin with?
Mr. WINDY. BOY. Some of them do not have any money.
Senator MELCHER. Thank you very much, John.
Mr. WINDY BOY. Do I leave this material?
Senator MELCHER. Yes.
[The prepared statement and letter follow:]

PREPARED STATEMENT OF THE CHIPPEWA-CREE BUSINESS COMMITTEE, SUBMITTED BY JOHN WINDY BOY, TRIBAL CHAIRMAN

The following testimony is in behalf of the Chippewa-Cree Business Committee. I appreciate the opportunity to express the health concerns of my people. This testimony will include:

1. The Indian Health Care Improvement Act Re-Authorization.
2. Existing inadequacies in health personnel, supplies, equipment and facilities.
3. The impact of budget cuts to IHS funding on the availability of services, personnel, training and priorities of treatment.
4. Unmet needs for water and sanitation facilities.
5. The impact of competitive bidding on the quality of, and access to health care.
6. Problems related to the 638 contracting process.
7. The functions and values of the CHR program.
8. Elevation of the position of the Director of IHS to the level of an Assistant Secretary within the Department of HHS.
9. Response to the recommendations made by the IHS task force on Contract Health Care Services to the director of IHS.

I. THE INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION

The Indian Health Care Improvement Act provides a declaration of Federal Policy regarding the provision of resources to improve the health status of American Indians and Alaska natives. This Act recognizes the unique relationship between governments. This relationship is originally derived by treaties. It has been supported by laws (The Snyder Act of 1921, the Indian Self Determination Act of 1975 and the Indian Health Care Improvement Act). According to all policy, comprehensive health care is an entitlement for Indian people.

This entitlement is based on law. It is not a welfare program.

In recognizing this fact, President Reagan's stated policy was to continue to strengthen the "government to government" relationship between the Federal Government and Indian tribes.

The actions of the Reagan administration have not followed his stated policy. Tribal leaders have not been consulted with. HHS has issued plans for aggressively pursuing the use of third party payment. They had issued policy on eligibility requirements. They have placed ceilings on manpower. All action initiated has presented serious problems for American Indians. The actions of this administration have also presented serious problems for I.H.S. They have reduced the service population and reduced the services provided. It has also reduced the payment of services provided by outside resources through contracts.

In regards to this critical action, the Chippewa-Cree Business Committee issues a number of recommendations. They are as follows:

1. Re-establish the "government to government" relationship with tribes. This can be accomplished by recognizing and consulting with tribal leaders for decision making on major IHS policy changes.
2. Establish a formula which would be equitable for direct funding to tribes. This formula must recognize a minimum funding level for small tribes.
3. Include Emergency Medical Programs within the Reauthorization. EMS programs are a major need because of the high incidence of accidents and injuries. Reauthorization language should address the need to define standards, establish funds for programs, training, operations and upgrading facilities.
4. Reauthorization of programs to meet the need for Indian Health manpower. The need for manpower and future critical needs in this area is already apparent. In our reservation already, attempts have been made to eliminate physician services. I believe actions of this type will continue until Indian people themselves can be trained for jobs in the fields of health professions. To date, the programs provided in this section of the Indian Health Care Improvement Act is the only reliable source of future Indian Health professions. It is also the only mechanism to protect us against Indian Health manpower shortages in the future. In order to protect future funding for these programs, language should include reauthorization for: (a) Title I, (b) Health Careers Opportunity Programs; and, (c) National Health Services Corps.

II. EXISTING INADEQUACIES IN HEALTH PERSONNEL, SUPPLIES, EQUIPMENT OR FACILITIES

I.H.S. has systematically received budget cuts, this fact added to increase cost of inflation, cost of living increases, etc., have started a series of cost saving procedures implemented by H.H.S. Among these procedures is the concept of implementing a policy to direct I.H.S. to operate its hospitals and clinics in the

same manner of county hospitals. Other concepts included are establishing I.H.S. funding with charging individuals and requiring third party reimbursements.

I am against any action of this kind. I understand that actions completed to implement this concept is already included in plans for F.Y. 1984. If this is a fact, please record my plea to this committee to immediately stop action, which will be devastating to American Indians.

I recognize this inadequate facilities personnel, equipment and supplies I.H.S. is facing in operating on limited funds, but I assure you the action H.H.S. is taking will not bring positive health changes for my people. Instead, I recommend increased funding to adequately meet the needs of I.H.S. in this area.

III. THE IMPACT OF BUDGET CUTS TO I.H.S. FUNDING ON THE AVAILABILITY OF SERVICES, PERSONNEL, TRAINING AND PRIORITIES OF TREATMENT

The major impact of budget cuts to I.H.S. is visible in the provisions of services, personnel, training and priorities of treatment. In the area of providing services, on our reservation alone, services for prevention of illness and injuries has diminished. Elective type of services are low priority. Indian people are required to search alternate resources for services.

In personnel, at the Rocky Boy Service Unit, positions which are needed to provide efficient services, have not been filled. This requires employees to perform increased activities, longer hours and creates less than optimum conditions. Training of our Health Center staff has been either delayed or eliminated creates problems with employees who require licenses as well as those professionals who require knowledge in current changes in their field, and for those who have desire to advance to higher levels in I.H.S.

Priorities of treatment is the area which has the highest degree of negativism. The priority for services in emergency situations for payment from Contract Care creates problems for people with chronic illnesses. They are only given outpatient treatment when there may be a need for hospitalization.

IV. UNMET NEEDS FOR WATER AND SANITATION FACILITIES

Major water and sewer problems stem from inadequate and poorly constructed HUD housing sites on the Rocky Boy Reservation.

This creates a financial burden on home owners, the tribe and often times, I.H.S. in emergency situations.

We are recommending that any contractor should be required to warrant their work for at least 5–6 years.

Home owners should be properly trained to maintain their systems also. This may alleviate some problems but can't help if a system has been inadequately installed.

Procurement time for completing the paperwork to get a water and sewer problem taken care of is far too long (90 to 120 days).

We are recommending this process time be shortened especially in a situation where funds are available.

The Chippewa-Cree Tribe submitted six needs for the jobs bill funds. Only two were funded at $55,000.00.

Why is this? Poverty level situations should be given first priority.

The cost of operation and maintenance of community water systems is horrendous. This service should be well planned and implemented to assure the best service possible for these systems.

We are aware the Tribe has some responsibility for this and we are requesting a more coordinated effort be made by I.H.S. in alleviating problems dealing with operation and maintenance of water systems.

V. THE IMPACT OF COMPETITIVE BIDDING ON THE QUALITY OF AN ACCESS TO HEALTH CARE

This area could be included in priorities of treatment, because competitive bidding has a direct effect on quality of care. When I.H.S. is required to accept the lowest bid for services, the quality of care is reduced. An example of this is: a contract may be issued for E.N.T. services. Surgeries are performed at a hospital 300 miles from the reservation. Postoperation care is not provided because it either was not written into the contract or there is not enough beds to allow patients appropriate recovery time. The patient is forced to travel six

hours to return home. Situations such as this example are happening. It is my opinion that even in countries without the medical technology or advance knowledge of the United States conditions such as this do not exist.

Another negative effect of competitive bidding concerns water samples of bacteriology readings. An area wide contract may be issued to the lowest bidder. The bidder physical location may be 2,000 miles away. Access to immediate information is not available because of distance.

I'm sure I could list many more negative issues but I'm sure you understand my concern for quality services for my people. I'm sure you understand general problems which surface when I.H.S. is forced to accept the lowest bidder on a contract.

VI. PROBLEM RELATED TO THE 638 CONTRACTING PROCESS

The Rocky Boy Health Board has contracted a number of programs via 638 with I.H.S. since 1979. Major problems that have risen initially and over the years deal specifically with:

(1) Contract Regulations.
(2) Administrative Policies (attached).
(3) "Continuing Resolutions" or Negotiations-Funding Timeline.
(4) Letter of Credit.
(5) Contract dollars are less than IHS would use to provide the same service.
(6) Hidden costs.
(7) Full benefits—contracting versus IHS employee.
(8) Reporting process.

It's difficult to make a 638 contract which provides health and human service fit contract procedures used by IHS for buying of other types of services.

In actuality, the 638 contract should follow the guidelines of a transfer agreement from IHS to tribes. Treating it as a contract which IHS uses to buy services other than human services makes it difficult in advancement of services and personnel.

Administrative policies attached to the law often hinder the contract activity. These policies effect specifically cash flow, reporting requirements, and benefits provided personnel such as training opportunities, insurances, etc.

"Continuing Resolutions" are a major problem in the contracting process. It's almost impossible to plan and provide a service when there is constant daily pressure of the program being cut tomorrow.

In part, this problem is created by the negotiation-funding timeline. Negotiations usually are held in August for the preceding fiscal year and funding is not assured until March or April into the fiscal year.

The Letter of Credit which most contracts are funded by has some problems also. The funding is approved monthly according to a prearranged ceiling. This ceiling does not consider or allow for unexpected expenses which often arise no matter how much planning is involved.

There is a reluctance by tribes to contract via 638 as the final analysis usually identifies not enough dollars to provide a specific service.

Often we've had to use general fund monies to assist a specific contract. This happens often when dealing with hidden costs. Costs that were not identified in the feasibility study or more often were identified and agreed on but the agreement was "lost in the shuffle" of personnel and paperwork.

These hidden costs are more easily handled by I.H.S. in their totality but create a burden on tribes and contract activity.

Many benefits which should come with contracting or agreed on beforehand are again often lost in the shuffle. Benefits such as training of I.H.S. staff which excludes contract staff and types of insurance benefits.

The reporting process is tedious and one often wonders who reads those reams of paper. Often the needed statistics are not gathered through this process and again, the funding is threatened. In this age of computers, it seems we should be able to develop some type of system so Congress never has to question the purpose behind funding requests.

Our recommendations are to:

(1) Change the status of 638 contracting to a transfer agreement.
(2) Cut back on administration policies, especially those which cause cash flow problems.
(3) Eliminate the continuing resolution process. Allocate funds in such a way so this is not needed. Change the negotiation funding timeline.
(4) Eliminate some of the Letter of Credit administrative policies.

(5) Open up contracting so tribes will have the freedom necessary to provide services at the same level as I.H.S.

(6) Hidden costs should be specifically outlined in all feasibility studies before contracting.

(7) Full benefits should be allowed contract personnel equal to I.H.S. personnel, especially in training.

(8) The reporting process should be designed so necessary statistics are on hand at all times.

VII. THE FUNCTIONS AND VALUES OF THE C.H.R. PROGRAM

The Chippewa-Cree Tribe of Rocky Boy, Montana, wish to express their concern over the drastic cutback in funds for the Community Health Representative (CHR) Program within the past two years. These funds have been contracted by the tribes from Indian Health Service (IHS) for the past twelve years to enhance the health delivery services provided by IHS. The CHR's play an important role as liaison between IHS and the community. As liaisons, they provide outreach and advocate services which creates a decrease in use of delivery services where there's an abuse of it. At other times, it creates an increase in use of services when there's a need to improve the health status in areas such as hypertension, diabetes, pre/post-natal care, immunizations, upper respiratory infections, emergency services, environmental health, alcohol and drug abuse counseling, and other identified areas of need which IHS as well as state and county officials have cited. They often provide preventative education to individuals, families, and classroom groups in these areas identified.

Because of the cuts in CHR funds in the last two years, we fear the worst in future appropriations. Therefore, we are requesting the assistance of all who are in a position to support us when the decision comes to appropriate funds to continue such an important program.

We are well aware of the language that came with the '83 CHR appropriations from the House of Representatives and we are willing to assist IHS in any way possible in developing an acceptable program-plan and evaluation process. We believe that the most important asset our program provides is the improved health conditions of our people. To do this, we have had to work with IHS as well as state and county health programs in a cooperative and coordinated effort. We have always felt the outcome was an accomplishment which has assisted us in meeting our priorities and program goals.

VIII. ELEVATION OF THE POSITION OF THE DIRECTOR OF I.H.S. TO THE LEVEL OF AN ASSISTANT SECRETARY WITHIN THE DEPARTMENT OF H.H.S.

My position on this issue is to elevate the director of I.H.S. to the level of an Assistant Secretary within the Department of Health and Human Services. Such a move would be beneficial to the Indian Health Programs. A positive result of this action would be immediate, the elevation would eliminate the bureaucratic layering throughout the system. A second positive result would be that the Director of I.H.S. would have direct access to the departments decision makers. An overall benefit would be that there would be greater concern and understanding of the Health Care delivery system at the highest department levels.

IX. RESPONSE TO THE RECOMMENDATIONS MADE BY THE I.H.S. TASK FORCE ON CONTRACT HEALTH CARE SERVICES TO THE DIRECTOR OF I.H.S.

The Directors task force on Contract Health Services recommended fundamental changes in: (1) eligibility; (2) service priorities; (3) resource allocations; (4) procurement; (5) claims process. In focusing on the above areas, the task force recommendations strikes at the very origins of services provided to Indian people, and laws subsequently enacted by Congress. Judicial, they addressed fundamental issues rulings, involving the delivery of health services by I.H.S. Any implementation of their recommendations require careful review from Tribal officials.

In my review of the task force report, I believe Tribal leaders need to be aware of the recommendations because they do deal with I.H.S. policies. I will comment on the issue as follows:

(1) *Eligibility.*—The task force requested clear and objective eligibility criteria be established. This criteria, they recommended should be derived from enrollment systems, where Indians obtain enrollment with I.H.S. for direct and

contract services. They also stress the need for an individual to satisfy the tribal membership and residency requirements. They do not recommend utilizing blood quantum.

(2) *Service priorities.*—The task force listed health services available to American Indians and Alaska Natives. These resources were listed to include: (A) Medicare; (B) Medicaid; (C) Veteran's Administration; (D) Crippled Children's Program; (E) Other State and Local Programs; and (F) Private Insurance.

The policy practiced by the I.H.S. has been for the local services areas to establish medical priorities. The recommendation for this area is I.H.S. will categorize services in the following categories:

(A) Clinical Care priorities in immunization screening, education, and periodic exams.

(B) Basic primary care, treatment of prevalent illness which have a significant impact on morbidity, primary and secondary hospital care. Included are "selected sophisticated" ambulatory services.

(C) Acute and life-endangering illnesses emphasizing geographic access to basic emergency services. Stabilization and referral to patients and their appropriate referral. Provisions or payment of tertiary or long-term treatment is not included.

The recommendation is that services in categories A through C receive high priority and that resources for clinical services be allowed on the basis of services listed in those categories. They also recommend that in the event of the availability of appropriated funds, two additional categories be considered:

(D) Tertiary, Chronic Maintenance and Support Services—These services would be primarily maintenance. They would not be preventative in nature nor restore health.

(E) Experimental measures which have not been proven effective. These services are those which cost to benefit ratio is low but is deemed necessary by the physicians.

The task force recommended its priorities apply to all I.H.S. clinical services, whether they are provided by I.H.S. or Tribal Contracts.

(3) *Resource allocation.*—The task force recommends I.H.S. allocate resources according to a method which incorporates the principle that all clinical care resource available to I.H.S. patients should be developed into a systematic rational and equitable program of health care services for the enrolled population.

(4) *Procurement policy.*—The task force supports the procurement of Contracted Health Services by Service Units.

(5) *Claims process.*—The task force recommends I.H.S. be reimbursed at rates computed according to the Medicare methodology.

They also recommend I.H.S. "aggressively" implement its requirement that patients use third party resources—public and private alike. They recommend billing individual Indian patients, billing insurance companies, and others. The reasoning behind this recommendation is that I.H.S. would retain whatever payment they received to provide additional clinical services and no longer remand such receipts to the U.S. Treasury. They also recommend the use of a fiscal agent system to process I.H.S. claims. The task force recognized the need to field that test their recommendation in this area. No field test was comand comment.

In light of an indepth view of the task force report, I will again state the recommendations they present require specific legislative authority. I believe there should be no timeline set on implementation of these recommendations. Implementations of the recommendations will have negative effects in Indian Health Services by further reducing their budget. It will also have negative effects on American Indians because of the total reduction of services provided and the method of paying for services will not insure quality care.

In further discussion of eligibility, CHS guidelines specifying eligibility of spouses who come from the same tribe but another country (Canada) affects a major population on the Rocky Boy Reservation.

Guidelines require proof of descendency which should be without question for Cree people from Canada who are married into the Chippewa-Cree Tribe of Rocky Boy.

We recommend that the Cree people be given the same leeway as the Blackfeet and Mohawks based on the stipulation of the Jay Treaty between the U.S. and Canada. Another basis would be the close interrelationship between the Cree of Canada and the Cree of Rocky Boy.

The Chippewa Cree Tribe of the Rocky Boy's Reservation

Phone 395-4478 or 395-4727 · Rocky Boy Route · Box Elder, Montana 59521

April 25, 1983

Senator John Melcher
Russell Senate Office Building
Room 253
Washington, D.C. 20510

RECEIVED MAY 0 2 1983

Dear Senator Melcher;

The Chippewa Cree Tribe is adamantly against President Reagan's proposal to initiate charges to Indians, based on their ability to pay, for health care services received through the Indian Health Service. While we have been assured that Indians will be served by IHS regardless of their ability to pay, the overall effect of this proposal would be a decided decline in fundamental health care on the Rocky Boy's Reservation.

As you know, we currently have a 72% average unemployment rate which runs as high as 85% unemployment at times. Many of those who are fortunate enough to have jobs make little more than the minimum wage; many also provide support for extended families. If enacted, the general effect of this legislation would be for individuals who are billed for medical services to avoid using the Indian Health Service Clinic in the future, except in the case of extreme emergencies. In essence, to charge for medical care would be to deny medical care, a situation which could have very serious consequences.

In terms of overall health and life expectancy, the Indian ranks at the bottom of the socio-economic ladder. Free medical care should be available to all who need it. Once again we see an example of the way in which the federal government sometimes provides incentives for individuals to remain on welfare as a means of obtaining more income and services than they could holding down a job. Free health care is equitable and assures that our people receive medical services whenever they require it. Enclosed is a list of communicable diseases and injuries treated by IHS published in Environmental Health Profile and Priority Projection, FY-1981: Rocky Boy's Service Unit, which provides documentation of the health problems on the reservation.

We ask your support in helping to defeat this measure.

Sincerely,

John Windy Boy
Chairman

Chief Rocky Boy

NOTIFIABLE COMMUNICABLE DISEASES (LAST FIVE YEARS)
Service Unit: ROCKY BOY'S

Disease	APC No.	FY 1980 No.	FY 1980 Rank	FY 1979 No.	FY 1979 Rank	FY 1978 No.	FY 1978 Rank	FY 1977 No.	FY 1977 Rank	FY 1976 No.	FY 1976 Rank
Upper Resp. Infection	300	1272	1	1498	1	1334	1	1094	1	1063	1
Tuberculosis,* Active	005 008	2	6	3	7	-		-		-	
Infectious Hepatitis	015	-		-		21	6	4	7	-	
Bacillary Dysentery	013	-		2	8	3	8	-		1	7
Otitis Media	250	4	5	7	5	350	2	356	2	597	2
Pneumonia	306	93	3	81	3	70	4	30	5	31	6
Influenz	305	45	4	17	4	16	7	19	6	59	4
Viral Encephalitis	061	-		-		-		-		-	
Gastro-Enteritis, Diarrhea	014	121	2	232	2	65	5	56	4	53	5
Trachoma	021	-		-		-		1	8	-	
Ecto-Parasitic	020	1	7	5	6	79	3	200	3	92	3

*Pulmonary and Extra Pulmonary.

Ambulatory Patient Care Report IC, 1st. Visits Only. XXXX

D. INJURIES - ACCIDENTS (LAST THREE YEARS)

SERVICE UNIT: ROCKY BOY'S

INJURIES	FY 1980 NO.	RANK	FY 1979 NO.	RANK	FY 1978 NO.	RANK
MACHINERY	1	10	39	5	43	6
ACCIDENTAL POISONING	14	7	23	8	8	12
ACCIDENTAL FALLS	100	1	6	4	335	1
FIRES & FLAMES	6	8	39	6	12	11
ENVIRONMENTAL FACTORS	1	10	1	14	40	7
STINGS AND VENOMS	21	6	13	10	21	9
ANIMAL RELATED INCL/BITES	56	2	62	3	35	8
CUTTING & PIERCING OBJ.	32	4	28	7	80	4
FIREARMS ACCIDENTS	0		2	12	1	14
MOTOR VEHICLE	44	3	10	11	18	10
SUICIDE ATTEMPT	3	9	2	13	6	13
INJ. PURPOSE INFLICT B/O	24	5	13	9	106	3
UNDETERMINED CAUSES	39		188	2	79	5
OTHER CAUSES	881		623	1	131	2
INVALID	15					
TOTALS	1238		1103		915	

Senator MELCHER. Our next witness is Jim Kennedy, tribal health director for the Blackfeet Tribe.

STATEMENT OF JIM KENNEDY, TRIBAL HEALTH DIRECTOR, BLACKFEET TRIBE

Mr. KENNEDY. My name is Jim Kennedy, health director for the Blackfeet Tribe. I have been requested by our chairman, Mr. Earl Old Person, to represent him at this hearing. And one of the main things he wants to emphasize at this hearing is to thank you, Mr. Melcher, for the work that you have done on behalf of the Indian people, and that the idea of holding these hearings is a good one because it gives us the opportunity to come in and sit down and briefly discuss and chat with you about some of our major problems.

Our No. 1 priority still is direct patient care, and will be probably till the end of time.

Another problem that keeps coming up that is of major concern is that of the unmet surgery list which is funded through the Contract Health Services. I have placed in our testimony some data information for you to look at. This information was accumulated by IHS physicians and contract medical people at the IHS facility in Browning.

If I might, I would like to call your attention to a line item called "Evaluations."

Also, I would like to call your attention to evaluations on medical evaluations, and the medical tests and medical consultants.

I would like to have it noted the high number of people who are placed in this category that have gone unfunded for unmet needs. This information is approximately 30 percent of what they figure the need is. And using a little arithmetic, that comes out to $1.2 million, just to cover what we have already identified.

The part about medical tests, medical consultants, and evaluations; I have taken a little time, talked to the physicians and the nurses and medical administrators at IHS facilities and asked them what these were, and they said, "Well, it is usually something that we want to refer out," or they do not know on the test part of it.

So, I guess the point of my testimony on this thing is, we would like to have you, or your committee, request IHS to establish an equitable distribution formula on Contract Health Services moneys, based on—well, it could be a number of things.

You briefly touched on it in your opening address. But we were looking at, based on unmet needs, trauma and caseload.

The problem goes much deeper than this. With the lack of funds that have come down in direct patient care and contract medical care, a lot of our physicians have developed a negative attitude toward staying on the reservation. We have been able to keep a doctor approximately 18 months. And this is averaging out about 18 months.

One of the main things that the physicians are saying is, "Well, if we had a way of seeing money coming in, or rewards for our efforts for what we are doing, then we might stay longer."

The other request that we have of your committee is that we are requesting that your committee request from IHS a proposed plan for billing third party units. And that these funds be utilized at the facility from which they were generated.

The reason that we make this request is that we have State, local government, school districts, and most of the employees carry health insurance; and yet a lot of them are Indian people. They are going to these IHS facilities, and their health insurance is not being billed.

Now, I have talked with some insurance people, Blue Cross of Montana in particular, and they tell us that unless we bill every individual that goes through the facility, that they will not pay for these services.

And with that, if you have any questions, I would be more than happy to try to answer them.

Senator MELCHER. Well, on that last point, do you know whether IHS has attempted to collect for the care unit? Do you know whether Blue Shield, or Blue Cross or whoever it is, has billed them?

Mr. KENNEDY. No, they do not bill them. They bill them if it is the case of a non-Indian, a white person, someone who is a nonmember. They cannot bill them. They do not have any billing system in place. Yet, they are able to collect medicaid/medicare funds, which I understand is kept in a slush fund down here in the Billings area office.

Senator MELCHER. We had to pass a law to get them to do that.

Mr. KENNEDY. We are going to have to maybe pass a law to get this opened up so we can get more funding.

Senator MELCHER. I know Congress is for it. Of the amendments we had in that 1980 reauthorization for Indian health care, it was a requirement. We were in doubt, we did not know whether they could have collected medicare/medicaid payments.

Maybe we are going to have to do the same on this. Obviously, if an employee of the government, or somebody else is using the Indian Health Service facility, for a procedure which is covered under their insurance, it should be collected by the Indian Health Service. That is a very good point.

There are not very many tribal patients who actually carry, on their own, private insurance coverage, are there?

Mr. KENNEDY. Statistically, they do not. But individuals who are able to afford it are seeing the need for having it. The need is becoming so great that they are buying it.

Senator MELCHER. Some of them are?

Mr. KENNEDY. Sure.

Senator MELCHER. Indian Health Service would not even ask for it?

Mr. KENNEDY. No. They cannot bill it anyway. See, our entire school system in Browning has a blanket coverage for their school employees, and most of them are Indians and they use IHS facilities, and the money just flies away. There is no way of collecting it.

Senator MELCHER. Well, we can correct that. Obviously, we had better correct it by law to make sure we correct it. The time is right now, we will put an amendment in this reauthorization act to clarify that.

If the insurance company is saying: "Well, no debt is incurred, and there is no obligation for the insurance company to pay," which is a neat way of saying: "We are going to hold down the costs on behalf of the insurance company."

But it is not logical or practical and there is no commonsense to that. Because, when you are paying for insurance, you are paying for the protection and whatever and wherever the service is received, even though it is the Federal Government. We will correct that.

Mr. KENNEDY. If I might add one more thing. This is not in my testimony, and this is concerning the CHR program. Since 1981 IHS has probably been funded at its highest level, and since that time, it has been decreased approximately 15 percent a year. The need has become so great that we have utilized our CHR program in various numbers of ways to offset the shortcomings in the IHS staffing. Environmental health is one place, and eyeglasses is another. But we have been more or less keyed to the idea at the Indian Health Service that we want better health for all Indian people.

So wherever there is a shortage and we can accommodate them, we have been doing so.

Senator MELCHER. How many CHR people do you have?

Mr. KENNEDY. Twenty-three CHR's.

Senator MELCHER. Do you need more?

Mr. KENNEDY. Of course, everybody would say to you that we need more in the sense that it creates employment, and that will create revenue.

Senator MELCHER. But are you comfortable with 23? Is it working now?

Mr. KENNEDY. We are making it work, yes.

Senator MELCHER. What about the mileage?

Mr. KENNEDY. Mileage is a very controversial subject. We have secured two buses from the Mass Transit Urban Act. We have been using those buses in the CHR program, mainly to transport. However, we have also opened it up to people who need medical appointments and this type of thing in all our outlying communities on the reservation.

Senator MELCHER. That has been very helpful, has it?

Mr. KENNEDY. Yes, it has. In fact, a lot of our elderly people have become acquainted with it, like if they want to go out and, say, get their mail, they call us up; we go pick them up and take them to wherever they would like to go.

Senator MELCHER. That is good. Now most of your hospitalized patients have been going to Cutbank and Great Falls and Shelby?

Mr. KENNEDY. Very few go to Shelby and very few go to Cutbank. Our main referrals are to Kalispell and Great Falls; to major medical centers.

Senator MELCHER. To Kalispell. Do you drive them there by ambulance?

Mr. KENNEDY. Depending on the nature of the injury or whatever it might be. Sometimes we transport them by helicopter.

Senator MELCHER. Same with Great Falls?

Mr. KENNEDY. Yes.

Senator MELCHER. Do you still have the option to refer a patient to Cutbank or Shelby if they prefer that, to be closer to home? Is that available to you?

Mr. KENNEDY. Very seldom, in the sense that it seems that IHS has taken the attitude that the physicians at Great Falls and Kalispell, wherever it might be, are specialized in certain areas to treat different trauma and this type of stuff; where in Cutbank, because of their remoteness, they do not have the physicians that can handle some of the cases.

I do not feel real comfortable talking about this particular subject, in that it is an area that the union service director would be able to handle more freely with you.

Senator MELCHER. We will pursue it with them, because there was a question a year or two ago about whether or not that option would be available.

Mr. KENNEDY. Oh, I am sure the option would be available.

Senator MELCHER. Some patients wanted to be closer to their famlies, in Great Falls or Kalispell, and we just want to be sure that option is open to the individual patient and their families.

Do you have any firm information on when the hospital is going to start construction?

Mr. KENNEDY. Yes, I attended a meeting with the A&M firm, and ROFEC, and IHS officials, from both Washington and Billings, here on June 22. As you know, the thing has been let for bid. The final closing date for bids will be August 16—or August 16 will be the day they open bids. On September 19, they hope to select a firm by then. And on September 30, in that neighborhood, they hope to have the ground breaking ceremony. Hopefully, we will make that.

Senator MELCHER. I hope it is on a Saturday. In other words, you feel pretty comfortable that the contract will be let shortly and construction would be started this fall?

Mr. KENNEDY. Yes.

Senator MELCHER. You have waited a long time. There has been a lot of slippage.

Mr. KENNEDY. The project first began 24 years ago.

Senator MELCHER. We have some friendships built up over that generation; 24 years is a generation, by the way.

Mr. KENNEDY. Yes.

Senator MELCHER. I think Congressman Yates made sure that there was no slippage of the funds while locking it into the appropriation bill of the House, and I think we owe him a big thank you. I believe again, the administration people wanted to grab the money for something else.

Mr. KENNEDY. Pay raises. Pay raises in IHS.

Senator MELCHER. The 14-percent pay raises.

Mr. KENNEDY. Is that it?

Senator MELCHER. Yes, that is it. Thank you very much.

Mr. KENNEDY. I thank you. A lot of that effort has come from your office also.

Senator MELCHER. We have been very anxious to get some medical care out there for the Indian people.

Thank you very much, Jim.

[The prepared statement follows:]

THE BLACKFEET TRIBE,
OF THE BLACKFEET INDIAN NATION,
Browning, Mont., July 7, 1983.

Senator JOHN MELCHER,
U.S. Senate, Select Committee on Indian Affairs,
Washington, D.C.

DEAR SENATOR MELCHER: This letter is to serve as an official appointment for Mr. Jim Kennedy to represent the Blackfeet Tribe at the Oversite Hearings on Indian Health Service scheduled on July 8, 1983.

Your cooperation on this matter will be greatly appreciated.

Sincerely,

EARL OLD PERSON,
Chairman, Blackfeet Tribal Council.

PREPARED STATEMENT OF JIM KENNEDY, HEALTH DIRECTOR, BLACKFEET TRIBE

Honorable Senator Melcher, my name is Jim Kennedy, Health Director for the Blackfeet Tribe. I have been requested by our Chairman, Mr. Earl Old Person, to represent him at this hearing on Indian Health Service.

The Blackfeet People are thankful to you for the concerns that you have shown the Indian people, and especially the efforts you have generated in the Tribe's attempt to secure a new health facility.

Our number one (1) priority still remains as direct patient care. However, another issue that stands out as a priority is that of the unmet surgery list of patients that are determined not life threatening by the I.H.S. physicians. Due to severe cut-backs in fiscal year 1982, I.H.S. placed limitations on services, to where only cases involving life and death are referred out to major medical providers. The funding level for this category listed under Contract Health Services has remained at the same funding level since fiscal year 1981, with the cost of health services increasing at a rate of 15 percent per year.

The following information was accumulated using I.H.S. Physicians' referral list for unmet health problems that they are unable to provide care for.

Procedure	Number	Estimated cost
Cataract removals	17	$59,500
Jones tubes	2	6,000
Corneal transplant	3	12,000
Eye muscle surgery	3	9,000
Chalazion removal	3	9,000
Pterygium removal	2	7,000
Entropion correction	4	12,000
Ocular prosthesis	1	1,100
Evaluations	45	3,375
Orthopedic devices	13	7,800
Arthrotomy	10	35,000
Arthrograms/poss. arthrotomy	9	36,000
Repair tendon	2	8,500
Pin removals	2	3,000
Patellar realinement	1	4,000
Lumbosacral fusion	1	4,000
Bone graft	1	4,000
Oxostosis excision	1	3,000
Evaluations	75	5,625
Hysterectomy	2	7,000
Tubalplasty	1	4,000
Cystoscopy	6	10,000
Medical tests	35	14,000
Podiatry exams	3	450
Medical consultants	350	26,250
Dental prosthetic services	93	55,600
Total		347,200

This information is estimated to be 30 percent of the total unmet need. Using this data, if $347,200.00 is 30 percent of the total unmet need the total would be approximately $1.2 million. I would like to call your attention to the line of evaluations, medical tests, and medical consultants. These are areas of medicine that the medical staff are unsure of. However, due to fiscal constraints imposed on the Service Unit, the physicians are forced to practice medicine according to available funds, thus having the potential of placing the patient in a position of not knowing what kind of medical problem they have, and not being able to acquire a second opinion.

It is our request that Indian Health Service be directed to establish an equitable distribution formula based on unmet needs, trauma, and caseload for contract health service funds.

The lack of funds creates much deeper problems in the area of recruitment and retention of qualified medical people. Clinical Director, Service Unit Directors, and other attending physicians are placed in a position of having to deny services to individuals. The average length of stay for a physician on a Blackfeet Reservation has been eighteen (18) months. The attitude that is instilled by the old physicians that are leaving to the new ones coming in is that of unhappiness. In attempts to help the limited budget, we are asking your committee to request information on I.H.S.'s proposed plan of action for securing third party funding for services at the local service units. It is also our request that these funds be

utilized for the facilities from which they were generated. Many of the people who are employed by the Bureau of Indian Affairs, I.H.S., the local school district, and state and local government officials are covered by health insurance, yet many of these individuals utilize the local I.H.S. facility, with their health insurance not being billed, thus losing a source of revenue.

The Blackfeet Tribe realizes that the problems in health care go on endlessly, however, we have presented to you our most pressing concerns. Once again, we would like to thank you for this opportunity to testify before your committee.

Senator MELCHER. The third witness will be Don Archanbault, director of Fort Belknap Tribal Council, and representing the Montana Health Board also. You are vice-chairman, are you not?

STATEMENT OF DONOVAN ARCHANBAULT, DIRECTOR, FORT BELKNAP TRIBAL COUNCIL, IN BEHALF OF THE MONTANA INDIAN HEALTH BOARD, AND THE FORT BELKNAP COMMUNITY COUNCIL

Mr. ARCHANBAULT. Yes, I am. I would like to thank you, Senator Melcher, for allowing us to be here, and for the efforts that you have extended to all Indian people across the Indian country in trying to remedy some of the wrongs and the needs of the Indian people themselves.

I would like to say that some of the things that you mentioned earlier: the CHR program, tribal sector funding for health care for Indian people, these kind of things I believe are going to be addressed possibly by every tribe that comes in here. And I would like to take the first part of my testimony and address things that are concerns of the Montana Indian Health Board as a board, and then I will go to the tribal presentation.

Senator MELCHER. Fine.

Mr. ARCHANBAULT. The Montana Indian Health Board is a nonprofit corporation chartered under the revised codes of the State of Montana, and is composed of six Montana reservation tribes. The organization has been in existence since 1974, and has in the past been funded by the Billings Area Indian Health Service.

The Montana Indian Health Board has not been funded for fiscal years 1982 and 1983.

The concerns of the Board cover the whole spectrum of health care delivery; however, I will focus on two major issues and touch on the others.

The first issue is, of course, the reauthorization of the Indian Health Care Improvement Act, especially title I as it applies to the Indian Health Manpower, because the Montana Indian Health Board is the sponsor of the Health Care Recruitment program which is funded through the Public Health Service.

In section 1 of the title, Indian Health Manpower, and I will quote the section, it says:

> The purpose of this title is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the service and private practice among Indians.

That was the intent of the whole bill itself, I believe. And my question is, you know, have we fulfilled that intent? I would have to say in some instances, yes, we have made an impact on the health care delivery in that we have graduated nurses, medical technologists, and a lot of administrators of health programs.

But when we look at the physicians that are available to continue serving Indian people at Indian hospitals, I do not believe the impact that we have made is really significant.

I think the reason for this is that the time that has lapsed since the implementation of the act has not been sufficient to realistically measure or gage the impact that we are looking for.

I believe a student entering medical school and funded through the act itself has not had time to complete and go back and really be used for the Indian people. And, I think that is a clear indication that we must look at reauthorizing the act, and setting forth the language that is needed to adequately fund these kind of things.

So, I think it is really crucial that the committee press for reauthorization of the bill. And programs like the Montana Indian Health Board have to be certain somehow that we are not omitted from the funding process, because they are the feeders for universities and medical schools that do not go out and recruit as actively as the HCOP program under the Montana Indian Health Board.

These universities get people that probably already have their undergraduate work done. We are looking at, right now, the grassroots part of recruitment where we are out into the high schools and the elementary grades looking, from that early age, for recruits to go into the medical field. And our only source of income in the past has been the Public Health Service, as far as the HCOP program is concerned.

The Montana Indian Health Board needs to be continued. In the testimony I have here, I have the resolutions and letters of support from all the tribes. We have been told at the area level that the reason we were not funded was because we are competing for money that would conceivably go out to the tribes.

However, that is questionable, in our estimation, because I believe the Indian Health Service is doing some work in the recruitment field itself under sections 103 and 104 of title I of the act.

We feel that we should have some input into that. We do not know how much money is in a scholarship program. We do not know who has been selected, or even who does the selecting.

Senator MELCHER. Well, going out and recruiting for students to pursue a higher education in a medical career is one thing. But what else—get on to the other things the Indian Health Board is doing. I think the recruiting part of it is just one item.

Mr. ARCHAMBAULT. The Montana Indian Health Board was originally designed to act as a liaison between the tribes and the area office. Each tribe assigned actual tribal council people to the board, and they were supposed to be looking at things that were of concern regarding Federal regulations as to how money would be spent, programs would be designed, and this kind of thing.

A lot of that has been done. A lot of it has not been done. But, I believe the Montana Indian Health Board is still the vehicle for the tribes in dealing with these kind of issues. Because it has all of the tribes together at a given time to discuss these issues among themselves.

I believe the only way that we can come up with the pertinent solutions to these problems is to have input from everybody at the same time and discuss whatever differences or agreements that we have. In that sense, the Montana Indian Health Board is very important to the tribes.

The second issue is the actual funding of the board itself and keeping it alive. We are a State-chartered organization. I am a member of that board. I have been assigned by the tribal chairman. I see a number of other board members in the audience today that have been assigned by the councils. I have letters of support, resolutions from the tribes supporting the Montana Indian Health Board. But we have been having difficulty getting funding. And section 102 of the act itself, title I, clearly states that tribal organizations shall be funded.

We have just been getting the run-around on that. I would like to have some kind of response to the Indian Health Service on what their views are and why the Montana Indian Health Board has been left out on the side, dormant for the last 3 years, in regards to funding.

Other issues that are concerns of the Montana Indian Health Board are the INMED program itself. We act as a feeder to that program. We act as a feeder to other medical schools in Washington, Idaho, Colorado. We go out, we have statistics here in the testimony that shows the exact number of students who have been contacted; the number of students who are in schools that have come through this program, and who are also going from here on into INMED.

I believe that INMED, the HCOP program, and the Montana Indian Health Board are grassroots programs that are actually having an impact on the health care delivery system of Indian people. The only way we are going to be able to continue with the activities which we have been engaged in over the years is to continue the act itself.

In summary, I must reiterate the fact that the Montana Indian Health Board recruitment program is the only grassroots recruitment agency for Indians who are interested in the medical field. The recruitment area covers Montana and Wyoming, and the program serves as a feeder to INMED. Both programs are nonprofit. They are Indian staffed. To eliminate either one of these programs which have been really valuable in the process would be a total detriment to Indian people across the country.

Our only input into whether they will be continued is through your office. And I would like to continue a little about the extended team concept at Indian Health Service which tribal programs and tribal organizations must have. There has to be some kind of unity and some kind of total commitment, by all the agencies involved, in order to overcome the shortcomings in funding for Indian health care for Indians.

The triagency agreements, or other agreements that are in existence between tribes and government bodies are there. But, I feel that we must begin to look at the implementation of those agreements.

We also have to begin dealing with county and State agencies in terms of who is the prime sponsor for health care services to Indians. We are working in that direction. I believe Jim might have testified on that a little earlier.

We have had meetings with State and county health people. They are continuing on other reservations. And there has to be some kind of an assault on the problem of funding and perhaps looking at prevention from the strong standpoint.

I want to thank you for letting me present the concerns of the Montana Indian Health Board, and I will answer any questions that you may have.

Senator MELCHER. You were never given an explanation of why it has not been funded for 2 years; is that correct?

Mr. ARCHANBAULT. I do not have any written documentation as to why we were not funded. I have some verbal statements that were made in meetings with Indian Health Service people. One being that Montana Indian Health Board would not be funded if we were actually competing for funds that would go directly to the tribes. But, we are a tribal organization.

Senator MELCHER. What was the name of the person, Indian Health Service employee, who was assigned to the Montana Indian Health Board as its director?

Mr. ARCHANBAULT. That was Larry Thomas. He is the special assistant to the area director.

Senator MELCHER. Was he assistant to the area director when he was serving on the——

Mr. ARCHANBAULT. We have never been able to get a clarification on that, sir. We have asked numerous times where the responsibility lies for the actions that took place during his tenure as the director of the Montana Indian Health Board and why he should not answer to some of the——

Senator MELCHER. He was running the Montana Indian Health Board for 2 years is that correct?

Mr. ARCHANBAULT. I would have to ask the current director, Leona, Bayliff. She might help us on that.

Senator MELCHER. Was it 2 years or 4, or what?

Ms. BAYLIFF. It was about 1 year, 1½ years, approximately.

Senator MELCHER. Eighteen months, approximately?

Ms. BAYLIFF. Eighteen months, approximately.

Senator MELCHER. During that time, is it your testimony that at Montana Indian Health Board he incurred some contracts?

Mr. ARCHANBAULT. Yes.

Senator MELCHER. Financial obligations?

Mr. ARCHANBAULT. Yes.

Senator MELCHER. Were they approved by others on the board or not?

Mr. ARCHANBAULT. We have no documentation that a lot of the expenditures were passed through the board, or approved by the board. The action was taken by himself.

Senator MELCHER. Well, Mr. Thomas took those actions; incurred debt that has not been paid?

Mr. ARCHANBAULT. That is right.

Senator MELCHER. Whose bills, Montana Indian Health Board?

Mr. ARCHANBAULT. Montana Indian Health Board has been trying to reduce those costs through——

Senator MELCHER. Those debts are the debts——

Mr. ARCHANBAULT. Yes, they are debts.

Senator MELCHER. Unpaid bills?

Mr. ARCHANBAULT. Unpaid bills.

Senator MELCHER. Who does the board owe?

Mr. ARCHANBAULT. The board owes right now, in travel, a number of tribes. They owe a Kelly Service bill. Perhaps Leona can expound on that a little bit.

Senator MELCHER. Please give your name so the reporter has it.

Ms. BAYLIFF. The main bills I would focus on right now would be owing to the tribes.

Senator MELCHER. How many thousands of dollars are we talking about?

Ms. BAYLIFF. Well, in total, overall, with vendor bills and tribes, it is hard to break down, but it is about $40,000 that is unaccounted for.

Senator MELCHER. You say not accountable?

Ms. BAYLIFF. Unaccountable.

Senator MELCHER. They are not paid either, are they?

Ms. BAYLIFF. No; they are not.

Senator MELCHER. Is there any other money owed?

Ms. BAYLIFF. There were other vendor bills, but we managed to pay those with other money.

Senator MELCHER. They are paid?

Ms. BAYLIFF. Yes.

Senator MELCHER. Do you think this is the reason IHS has not funded Montana Indian Health Board?

Mr. ARCHANBAULT. Yes; we feel that.

Senator MELCHER. It is an interesting point. IHS has somebody running the show, incurring bills, and then, it is your feeling, after that has happened, that they decide to make up for it by not funding the Montana Indian Health Board?

Mr. ARCHANBAULT. We do not know what their motives are, sir.

Senator MELCHER. They must have some explanation. Is Mr. Thomas no longer running the Indian Health Board?

Mr. ARCHANBAULT. He is not.

Senator MELCHER. Is he running the area office?

Mr. ARCHANBAULT. Yes, he is.

Senator MELCHER. Is he supervising the area director, do you think?

Mr. ARCHANBAULT. I have no idea, sir.

Senator MELCHER. That will be an interesting question. We will have to ask Windy Boy and Jim Kennedy.

Mr. ARCHANBAULT. I have one more issue regarding Montana Indian Health Board, sir. That is, other travel incurred by a former director, Barney Old Coyote, and I wrote a letter to you regarding this issue.

Senator MELCHER. We are not going to get in the middle of that one. Barney has a suit against somebody, and we are not going to muddy the waters any further than they are.

Mr. ARCHANBAULT. Well, the only reason I wanted to raise it is because the current area director signed travel vouchers for payment for Mr. Old Coyote, and at the same time he requested payment from the Montana Indian Health Board. We advanced him with the idea that the money would be paid back. No one seems to know whether Barney was actually paid or not. We have not been able to get that from anybody.

Senator MELCHER. We have all sorts of problems shoved at us. We have lawyers on each side shoving them at us. We are not going to get involved in that. We are going to let the lawyers handle that.

Mr. ARCHANBAULT. That is all I have from the Montana Indian Health Board.

[Material submitted by the Montana Indian Health Board follows. Testimony resumes on p. 79.]

MONTANA INDIAN HEALTH BOARD

1215 - 24th St. West - Suite 110 • P.O. Box 91270 • Billings, Montana 59102 • Ph. (406) 656-2269

BOARD OF DIRECTORS

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Suite 210
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HEALTH CAREERS RETENTION AND AWARENESS
Suite 210
656-3292

June 1, 1983

RECEIVED JUN 13 1983

The Honorable John Melcher
1123 Dirksen Senate Office Building
Washington, D. C. 20510

Re: Request for Help - Urgent

Dear Senator Melcher:

The Montana Indian Health Board has authorized me to request your assistance in resolving some issues between the Billings Area Indian Health Service and the Montana Indian Health Board. The Montana Indian Health Board is a nonprofit corporation organized under the laws of the State of Montana for the purpose of promoting and informing the Montana Indian Tribes on Indian health issues and services.

Approximately two years ago the Montana Indian Health Board was under the supervision of a Billings Indian Health Service employee who was on an IPA assignment to the Montana Indian Health Board as its director. During that time, the director, without the knowledge or approval of the Montana Indian Health Board, incurred debts and mismanaged contract funds from the Indian Health Service.

The Federal Bureau of Investigation has checked into the matter from a criminal standpoint, and has found insufficient facts to warrant a grand jury investigation. However, the fact remains that the indebtedness and mismanagement of these contracted funds has placed the MIHB in financial jeopardy and threatens its continued existence.

The Indian Health Service is disavowing any responsibility for the conduct of the IHS employee who was on IPA as director of the Montana Indian Health Board. Further, IHS is utilizing those financial problems against the Montana Indian Health Board in an effort to deny any funding for the continuing operation of the Montana Indian Health Board.

The Montana Indian Health Board is requesting whatever assistance you may be able to offer to the Board in order to rectify this matter. We would also request that Ms. Jean Wrenn, Special Counsel - Senate Select Committee on Indian Affairs, be appointed to investigate this matter in order to assist the Montana Indian Health Board in resolving these financial issues and strengthening the continuing existence of the Montana Indian Health Board.

Whatever consideration you may be able to provide the Montana Indian Health Board will be greatly appreciated.

Sincerely,

Ada White, Chairman
Montana Indian Health Board

AW:da

PREPARED TESTIMONY OF THE
MONTANA INDIAN HEALTH BOARD

The Montana Indian Health Board is a nonprofit corporation chartered under the revised codes of the state of Montana, 1947, and is composed of six Montana reservations and one Wyoming reservation tribes. The organization has been in existence since 1974 and has in the past been funded by the Billings Area Indian Health Service. The Montana Indian Health Board has not been funded for fiscal years 1982 and 1983.

The concerns of the Board cover the whole spectrum of health care delivery; however, I will focus on two major issues and touch on the others.

The first issue is, of course, the reauthorization of the Indian Health Care Improvement Act. The Board's main concern is Title I, Indian Health Manpower. Section 101 clearly states the intent of the Title, and I quote "The purpose of this title is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the service and private practice among Indians." Has the intent been fulfilled?

Based on the statistics we have, I would have to say that, yes, we are making an impact on the problem. But, by the same measures, the impact is not significant. The reason for this is that the time that has elapsed since the implementation of the Act has not been sufficient to realistically gauge the impact. True, there have been nurses, medical technicians, and administrators graduated during the life of the Act, but how many physicians have graduated? If a student did begin schooling toward a career as a physician the same year that the Act was

implemented and was funded by the Act, we will not see him or her for probably two more years. From that standpoint, the intent of the Act will never be fulfilled, which clearly indicates that the Act needs to be reauthorized.

In the reauthorization bill, the language should be definitive in that community based programs such as the Montana Indian Health Board are not omitted from the funding process. Currently the Montana Indian Health Board's Health Careers Recruitment Program acts as the "feeder" to the medical schools in North Dakota, Colorado, and Washington. (The Health Careers Recruitment Program is funded by the Public Health Service.) The language proposed in the Federal Register dated May 26, 1983, categorically eliminates the Health Careers Recruitment Program from further funding from that agency. This, again, abrogates the intent of the Act.

The second issue that we want to address is the funding of the Montana Indian Health Board.

Section 102(a) clearly defines programs that "shall" receive grants under the Act. The Montana Indian Health Board has submitted proposals for funding the last two fiscal years that were endorsed by the tribes and subsequently turned down by the Indian Health Service Area Director. Neither the Board nor the tribes were ever informed in writing the reasons for not being funded. The Montana Indian Health Board has always contended that the Board should be the prime sponsoring agency for all Title I programs in the Billings area. Last year (1982) only five universities were funded under this section 102.

Currently the Billings Area Indian Health Service office is administering programs funded under Title I, Sections 3 and 4. The Montana Indian Health Board and the tribes do not know the extent of the funding nor the recipient of the scholarships. This action by the area office circumvents the law and excludes the tribes from participation. The Board and the tribes should have some discretion or control in the selection process for scholarship recipients.

Other issues of concern are:

1. The INMED program should be included as a line item on the appropriations for PL 94-437 FY 84.
2. The Board also feels that the Select Committee must continue because it is the only real vehicle Indian citizens have as a voice in government.

All other health issues will be addressed by the individual tribes.

In summary, I must reiterate the fact that Montana Indian Health Board's Health Careers Recruitment Program is the only grass-root recruitment agency for Indians who are interested in the medical field. The recruitment area covers Montana and Wyoming. The program serves as a feeder to INMED, and both programs are non-profit, Indian-staffed organizations. To eliminate either of these programs would be a detriment to the Indian population and disadvantaged students in the states of Montana and Wyoming. One must also consider the economic impact on both states.

The attachments are documentation on the position we have taken on these issues.

Thank you.

HEALTH CAREERS RECRUITMENT PROGRAM
FIGURES INDICATE THE YEARS 1978-1983

Total number of Workshops conducted: 14

Total number of workshop students: 492

Number of High Schools recruited from: 28

Workshop attendance breakdown according to Reservation and number of students (male and female)

	Total	Male	Female
BLACKFEET	39	6	33
CROW	69	25	44
FLATHEAD	84	21	63
FORT BELKNAP	53	10	43
FORT PECK	59	22	37
ROCKY BOY	52	15	37
NORTHERN CHEYENNE	52	13	39
WIND RIVER	63	11	52
BILLINGS AREA	21	6	15
	492	129	363

Health Career Professions that workshop students were interested in:

MEDICINE	40	RADIOLOGY	7	HUMAN SERVICES	3
OPTOMETRY	4	PHYSICAL THERAPY	10	CORRECTIONAL THERAPY	1
DENTISTRY	29	NUTRITION	4	HISTOLOGY	1
VETERINARY MEDICINE	25	MEDICAL RECORDS	1	MEDICAL SECRETARY	2
OSTEOPATHY	0	ENVIORNMENTAL HEALTH	2	MEDICAL ASSISTING	2
PHARMACY	14	CHILD HEALTH ASSOCIATE	1	BIO-MEDICINE	1
PODIATRY	0	NUCLEAR MEDICAL TECHNOLOGY	1	UNDECIDED	101
NURSING	59	BIO-CHEMISTRY	1	UNKNOWN	107
MEDICAL TECHNOLOGY	10	PARAMEDIC	1	NOT INTERESTED	16
SOCIAL WORK	11	SPEECH THERAPY	2	OTHER	23
PSYCHOLOGY	8	HOSPITAL ADMINISTRATION	5		

Number of workshop students attending college: 106

Students enrolled in health programs: 49

NOTE: A workshop student will begin his first year of medical school at Stanford University in fall of 1983.

A student completed a four year program in medical technology in spring of 1983 and will enter medical school in the fall.

Two students completed their education in registered nursing. One student is continuing on into medical school.

Two students completed training programs in medical assisting and Optical technology.

25-642 0 - 83 - 3

MONTANA INDIAN HEALTH BOARD

1215 - 24th St. West - Suite [illegible] P.O. BOX 31176 • Billings, Montana 59107 • Ph. (406) 656-2269

110

[COMMENTS ON FEDERAL REGULATIONS]

BOARD OF DIRECTORS

BLACKFEET:
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Philip Rattler, Jr.

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656-2269

HEALTH CAREERS RETENTION AND AWARENESS
Suite 210
656-3292

June 24, 1983

Director, Division of Disadvantaged Assistance
Bureau of Health Professions
Health Resources and Services Administration
Parklawn Building, Room 8A-09
5600 Fishers Lane
Rockville, Maryland 20857

Re: Amendment to Comment - Federal Register, Vol. 48, No. 102, Thursday, May 26, 1983/Notices - Preliminary Application Announcement, Proposed Funding Preferences and Grant Orientation Conferences for the Health Careers Opportunity Program

Dear Sir:

Please note the following amendments to our letter dated June 21, 1983:

1. University of Colorado Medical Center is now University of Colorado Health Sciences Center.

2. The community feedback is that they oppose the percentage rate, and they question whether or not it is necessary to have a percentage rate.

   As the Board, we do not feel that the 5% is adequate, and we feel that it is not necessary to have a percentage rate.

Sincerely,

Ada White, Chairman
Montana Indian Health Board

copies to: Dr. Joseph Stevens
100 senators U.S.
2 U.S. reps. from Mont.
MIHB members

LB:da

June 22, 1983

To Whom it May Concern:

We would like for you to review the copy of the Federal Register, and we seek your support to have community organizations participate in the Health Career Opportunity Program for disadvantaged.

The comments on the attached Federal Register are due June 27, 1983

Sincerely,

Ada White, Chairman
Montana Indian Health Board

da

Enc.

MONTANA INDIAN HEALTH BOARD

1215 - 24th St. West - Suite 100 • P.O. Box 31278 • Billings, Montana 59107 • Ph. (406) 652-1278

June 21, 1983

BOARD OF DIRECTORS

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Suite 210
656-3292

Director, Division of Disadvantaged Assistance
Bureau of Health Professions
Health Resources and Services Administration
Parklawn Building, Room 8A-09
5600 Fishers Lane
Rockville, Maryland 20857

Re: Comment - Federal Register, Vol. [illegible], No. 103, Thursday, May 26, 1983 Notices - Preliminary Application Announcement, Proposed Funding Preferences and Grant Orientation Conferences for the Health Careers Opportunity Program

Dear Sir:

Please find attached hereto the Comment and Statement of the Montana Indian Health Board relative to their Health Careers Opportunity Program which provides recruitment, identification, retention, selection and awareness activities in health professions for Montana and Wyoming Indians and other disadvantaged individuals. It is the position of the Montana Indian Health Board that the Proposed Funding Preferences under the authority of Section 799 of the Public Health Service Act will effectively eliminate the HCOP Program of the Montana Indian Health Board and all other Health Careers Recruitment Programs similarly situated which provide those same functions and services in the health professions.

States such as Montana and Wyoming, which do not have health professional or medical schools, will be seriously effected by the Proposed Funding Preferences if they are implemented as written. Moreover, the Proposed Funding Preferences raise serious questions as to whether or not they are in accordance with the intent and purpose of the Public Health Service Act of August 13, 1981, 42 USC Section 295 g-7. Further, if the Proposed Funding Preferences are implemented, it would raise questions as to whether or not they are in violation of the equal protection guarantees under federal law and the United States Constitution.

These issues shall be addressed more specifically in the attached Comment and Statement of the Montana Indian Health Board relative to the Proposed Funding Preferences.

Sincerely,

Ada White, Chairman
Montana Indian Health Board

AW:FL:lb

MONTANA INDIAN HEALTH BOARD

COMMENT AND STATEMENT
ON PROPOSED FUNDING PREFERENCES
AND GRANT ORIENTATION CONFERENCES
FOR THE HEALTH CAREERS OPPORTUNITY PROGRAM

I

HEALTH CAREERS OPPORTUNITY PROGRAM OF THE MONTANA INDIAN HEALTH BOARD
HISTORIAL PERSPECTIVE

The Special Health Career Opportunity Grant Program was implemented in 1972 under Section 774(b) of the Health Manpower Education Initiative Awards component of the Comprehensive Health Manpower Training Act of 1971, P.L. 92-157. This program provided support to health professions, schools and other public or priviate nonprofit health or educational entities to design and implement projects which identified, motivated, recruited, and retained socioeconomically and educationally disadvantaged individuals interested in or pursuing a health profession. The successor of this act was the Health Professions Educational Assistance Act of 1976. Both of these acts have provided funding support for the Montana Indian Health Board to disseminate information regarding health career opportunities to Indians and other disadvantaged individuals of Wyoming and Montana and to help with identification, recruitment, and selection of Indian students and other disadvantaged individuals attempting to be admitted and enrolled in pre-professional or professional schools.

The Montana Indian Health Board's Health Careers Recruitment Program has been in existence since 1975 when it was funded for its first year of operation through the American Indian Physicians' Association, through the Special Health Career Opportunity Grant Program for one year, and the Health Professions Educational Assistance Act of 1976 thereafter.

Since its inception, the Indian Health Careers Recruitment Program has established itself as the primary linkage between Montana-Wyoming Indian Reservations and the multifarious health training and education programs available to Indian people. The program has extensive experience in providing recruitment, identification and retention, and awareness activities for Montana-Wyoming Indian reservations.

The American Indian, in spite of the affirmative action efforts of schools providing professional health education, has been and still is more significantly under-represented within most health professional schools and career positions than any other minority.

In its six years of operation, the health career seminars, recruitment trips, the resource library, and the follow-up services provided by the program have all proven to be effective means of directing increased numbers of Indian students towards careers in health. Since realizing the goal of increasing the number of Indian people entering health professions is a long-range one, it will be at least another two years before Indian students in health professions schools recruited through this program can be counted.

Many of the students who were inspired by the program to enroll in health curricula at various colleges and universities are now well into their junior and senior years.

If Congress is to realize the goal of seeing increased numbers of Indians entering health professions, it is essential that the continuity of identification and recruitment activities provided by the Indian Health Careers Recruitment Program be continued. Clearly the recruitment, retention, and selection component of the total Health Career Opportunity Program effort is the starting point for motivating and stimulating the interest of Indian youth in pursuing health careers. The Montana Indian Health Board feels strongly that the only effective approach to recruitment of Indian people is a grass roots effect done by Indian people.

The Montana Indian Health Board is an Indian controlled organization representing six Montana reservations. The board, since 1974, has developed programs that fit under two major goals expressed by Congress in passing P.L. 94-437:

1. To ensure the health status of Indian people is brought up to parity with that of the general U.S. population, and

2. To achieve the maximum participation of Indian people in Indian Health Programs.

Dr. Dean Chavers, President of Bacone College, Bacone, Oklahoma, prepared a chart showing the number of Indians in each profession compared to the total in the United States. These statistics are as of February 1979.

Field of Specialization:	Total Indian:	Total U.S.:	Needed for Parity
Medical Doctor	125	340,000	1,435
Dentist	6	120,000	546
Nurse	644	750,000	2,796
Veterinarian	3	30,000	137
Podiatrist	2	7,120	31
Pharmacist	30	125,000	543
Speech Pathologist	10	16,000	63
Optometrist	12	19,265	76
Psychiatrist	18	17,383	62

The Montana Indian Health Board has accomplished a great deal in a very short period of time in developing a model approach to increasing Indian representation within the health professions. In the process of providing recruitment, identification, retention, selection and awareness activities to disadvantaged individuals, HCOP has primarily worked with these institutions: (There are no medical schools located in Montana or Wyoming.)

Institutions of Post Secondary Education

University of Montana*
Montana State University*
Eastern Montana College*
Rocky Mountain College
Northern Montana College
Western Montana College
University of Wyoming
Central Wyoming College
Casper College
Sheridan Junior College
Northwest Community College
Western Wyoming College
Eastern Wyoming College;
Laramie County Community College
College of Great Falls
Flathead Valley Community College
Carroll College
Miles City Community College
Dawson Community College
Big Horn Community College
Blackfeet Community College
Salish and Kootenai Community College
Dull Knife Community College
Ft. Peck Community College
Central Wyoming Community College
INMED, University of North Dakota*
University of Colorado Medical Center*

* Have formal Education Assistance Agreements with the Health Careers Recruitment Program.

Reservations

Blackfeet
Crow
Flathead
Fort Belknap
Rocky Boy
Northern Cheyenne
Wind River
Fort Peck

25 High Schools on and near Montana and Wyoming Reservations

Rocky Boy	Riverton
Box Elder	Wind River
Havre	Wyoming Indian
Dodson	Browning
Harlem	Ronan
Hays	Polson
Plenty Coups	St. Ignatius
Hardin	Arlee
Lodge Grass	Charlo
Labre	Hot Springs
Busby	Two Eagle River
Colstrip	Billings
Lander Valley	

The Health Careers Recruitment Program has been successful in its endeavo[illegible] increase the number of Indian people in the health professio[illegible]. There has been a significant increase in the interest and success in the number of Indian people and other individuals from disadvantaged backgrounds in the health professions since the inception of this program.

This has been accomplished through the extensive HCOP program of the Montana Indian Health Board. The initial interest in health professions is primarily stimulated by the Montana Indian Health Boards HCOP program. This initial interest has developed the critical pool of applicants in health profession from which health profession schools and other allied health schools and programs select applicants.

II

PUBLIC HEALTH SERVICE ACT OF AUGUST 13, 1981. (42 USC SECTION 295 g-7)

The authority for implementing the proposed funding preferences are contained in 42 USC Section 295 g-7 which provides:

"EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS"

Sec.787 (295g-7) (a)(1) For the purpose of assisting individuals from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, to undertake education to enter a health profession, the Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, public health, dentistry, and podiatry and other public or private nonprofit health or educational entities to assist in meeting the costs described in paragraph (2).

(2) A grant or contract under paragraph (1) may be used by the health or educational entity to meet the cost of :

(A) identifying, recruiting, and selecting individuals from disadvantaged backgrounds, as so determined, for education and training in a health profession.

(B) facilitating the entry of such individuals into such a school.

(C) providing counseling or other services designed to assist such individuals to complete successfully their education at such a school.

(D) providing for a period prior to the entry of such individuals into the regular course of education of such a school, preliminary education designed to assist them to complete successfully such regular course of education as such a school, or referring such individuals to institutions providing such preliminary education, and

(E) publicizing existing sources of financial aid available to students in the education program of such a school or who are undertaking training necessary to qualify them to enroll in such a program.

(b) There are authorized to be appropriated for grants and contracts under subsection (a)(1), $20,000,000 for the fiscal year ending September 30, 1982, $21,500,000 for the fiscal year ending September 30, 1983, and $23,000,000 for the fiscal year ending September 30, 1984. Not less than 80 percent of the funds appropriated in any fiscal year shall be obligated for grants or contracts to institutions of higher education and not more than 5 percent of such funds may be obligated for grants and contracts having the primary purpose of informing individuals about the existence and general nature of health careers."

It is clear from the face of the statute that the intent and purpose of Section 295 g-7 is to assist individuals from disadvantaged backgrounds to pursue an education in order to enter a health profession such as medicine, dentistry, etc. Further, the language of the statute expressly contemplates the participation by organizations such as the Montana Indian Health Board and its Health Careers Opportunity Program.

The Montana Indian Health Board is a public nonprofit health entity as specifically provided in subsection (a)(1) of Section 295g-7. The Health Careers Opportunity Program of the Montana Indian Health Board provides those services and engages in those functions expressly provided in subsection (a)(2) of Section 295g-7. (See Section I of this Comment and Statement).

Although the Montana Indian Health Board is not an institution of higher education, its Health Careers Opportunity Program has several educational assistance agreements with institutions of higher education. This is specifically for the purpose of providing service and engaging in those functions expressly provided in subsection (a)(1) of Section 295g-7. It is extremely critical to fund an organization such as the Health Careers Opportunity Program of the Montana Indian Health Board because there are no institutions of higher education, as set forth in subsection (b) of Section 295g-7 who could carry out the purpose of the act to provide educational assistance to individuals from disadvantaged backgronds. The service area of the Health Careers Opportunity Program of the Montana Indian Health Board is rural Montana and Wyoming, which has a large Indian population who fit within the criteria of individuals from disadvantaged backgrounds.

The prior funding preferences contained in Federal Register Vol. 45, No. 171 dated Tuesday, September 2, 1980, contemplated the participation of Health Careers Opportunity Programs such as the existing HCOP Program of the Montana Indian Health Board. However, it appears that Health Careers Opportunity Programs of this nature will be effectively eliminated by the Proposed Funding Preferences contained in the Federal Register, Vol. 48, No. 103 dated Thursday, May 26, 1983, Notices.

III

PROPOSED FUNDING PREFERENCES, FEDERAL REGISTER, VOL. 48, No. 103, THURSDAY, MAY 26, 1983 NOTICES

The funding preferences for the Health Careers Opportunity Program contained in the Federal Register, Vol. 48, No. 103, dated Thursday, May 26, 1983, effectively eliminates Health Careers Opportunity Programs such as the HCOP Program of the Montana Indian Health Board. The Proposed Funding Preferences identifies those individuals from a disadvantaged background to mean; "individuals who (a)comes from an environment that has inhibited the individual from obtaining knowledge, skill, and ability required to enroll and graduate from a health professional school or from a program providing education or training in an allied health profession...".

This definition of an individual from a disadvantaged background is specifically applicable to Indian people and other individuals from a disadvantaged background in the states of Montana and Wyoming. However, the Proposed Funding Preferences will deprive those "individuals from a disadvantaged background" from an equal opportunity to pursue an education in the health professions. Montana and Wyoming do not have health profession schools which would fall within funding preferences (1).

Moreover, funding preferences: (2); (3); and (4) provide for the funding of higher education only, and not for Health Careers Opportunity Programs such as the one functioning under the Montana Indian Health Board. Furthermore, there are no institutions of higher education within the states of Montana and Wyoming which have a program which is actively providing recruitment identification, retention, selection, and awareness activities in the health professions for disadvantaged individuals. The Health Careers Recruitment Program of the Montana Indian Health Board does not fall within preference number (5) since that preference is specifically applicable to training centers for allied professions. However, that is not to say, that the HCOP Program of the Montana Indian Health Board does not recruit individuals for allied health professions. On the contrary, the HCOP Program does actively recruit disadvantaged individuals for the allied professions and engages in the same activities as it does for recruiting individuals from disadvantaged backgrounds in the health professions.

The proposed funding preferences, on page 23712, state that the greatest weight will be given to applicants in funding preference number (1) and decreasing respectively through funding preference (5) On the face of the Proposed Funding Preferences and permeated throughout the five preferences, reveals an absolute disregard for community HCOP programs such as the one functioning under the Montana Indian Health Board. All of the preferences, with the exception of preference (5), state that an applicant must be an institution of higher education. This language totally eliminates community organizations who have HCOP programs, in favor of universities and colleges. Furthermore, the proposed funding preferences contravenes the intent and purpose of Public Health Service Act of August 13, 1981, (42 USC Section 295 g - 7).

Title 42 USC Section 295g - 7 specifically contains language which authorizes community organizations such as the Montana Indian Health Board HCOP program. This unequal application of the funding preferences, in favor of universities and colleges, verges on a denial of equal protection to individuals from disadvantaged backgrounds in the states of Montana and Wyoming for all the reasons stated herein.

The Public Health Service Act of August 13, 1981, 42 USC Section 295g - 7, was not intended to contravene the equal protection clause of the fifth amendment of the United States Constitution. Further, if the proposed funding preferences are in fact implemented, they may violate Title 42 USC Section 2000 d which states:

> "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

It is conceivable that this statute would be violated if the proposed funding preferences are implemented and all the funding is received by universities and colleges and exclude HCOP community organizations such as the one under the Montana Indian Health Board. The HCOP program of the Montana Indian Health Board, is basically a multifaceted program for recruiting individuals from disadvantaged backgrounds at the community level. It is extremely questionable whether or not a university or college could maintain a recruitment program as extensive as the HCOP program of the Montana Indian Health Board. Therefore, there would be individuals from disadvantaged backgrounds in the states of Montana and Wyoming who would be denied those services and assistance provided by the existing HCOP program of the Montana Indian Health Board.

Federal agencies, such as the Division of Disadvantaged Assistance, Bureau of Health Professions, Health Resources and Services Administration, are mandated to effectuate the provisions contained in Title 42 USC Section 2000 d by the enactment of 42 USC 2000 d - 1. If these proposed funding preferences are implemented, as written, the Federal agency responsible for the implementation would not be effectuating the provisions of 42 USC Section 2000 d.

CONCLUSION

It goes without saying, that community organizations such as the HCOP program of the Montana Indian Health Board is essential, and it must be funded in the future in order to increase the number of Indians and other individuals from disadvantaged backgrounds in the health professions. The Proposed Funding Preferences must be amended to include community HCOP programs to effectively recruit and provide associated services to individuals from disadvantaged backgrounds who are seeking assistance in pursuing an education in health professions and allied health professions.

[Pages 23710-12 of the Federal Register, Vol. 48, No. 103, Thursday, May 26, 1983, Notices, herewith submitted, are retained in the committee files.]

ARTICLES OF INCORPORATION

SECRETARY OF STATE
STATE OF MONTANA

NOV 23 1982

MONTANA INDIAN
HEALTH BOARD

Jim Waltermire
Secretary of State

State Capitol
Helena, Montana 59620

Novvember 22, 1982

Ada White
Montana Indian Health Board
1215 - 24th Street West - Suite 110
Billings, Montana 59102

Dear Ada:

Enclosed is a Certificate of Good Standing for MONTANA INDIAN HEALTH BOARD, a Montana corporation.

Thank you for your check No. 1834 in the amount of $2.50.

Wishing you a good day!

Sincerely,

Florence Armagost

FLORENCE ARMAGOST
Chief, Corporations Bureau

FA:mo
Enclosure

Office of the Secretary of State

STATE OF MONTANA

I, JIM WALTERMIRE, Secretary of State of the State of Montana, do hereby certify that on

May 10, 1974

MONTANA INDIAN HEALTH BOARD

duly filed its Articles of Incorporation in this office and on said date was created a body politic and corporate.

I further certify that no notice or decree of dissolution has been placed on record in this office by said corporation and that so far as my records indicate the corporation is in good standing under the laws of the State of Montana and authorized to transact its business and conduct its affairs in this State.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Montana, at Helena, the Capital, this 22nd day of November

A.D. 19 82.

Jim Waltermire

JIM WALTERMIRE

Secretary of State

Office of the Secretary of State

OF THE

STATE OF MONTANA

CERTIFICATE OF AMENDMENT
TO CERTIFICATE OF INCORPORATION

I, FRANK MURRAY, Secretary of State of the State of Montana, do hereby certify that duplicate originals of Articles of Amendment to the Articles of Incorporation of

BILLINGS AREA INDIAN HEALTH BOARD

duly executed pursuant to the provisions of Section 35-2-208 of the ~~Revised Codes of Montana, 1947~~ Montana Code Annotated, have been received in my office and found to conform to law.

NOW, THEREFORE, I, FRANK MURRAY, as such Secretary of State, by virtue of the authority vested in me by law, hereby issue this Certificate of Amendment to the Certificate of Incorporation of

MONTANA INDIAN HEALTH BOARD
formerly
BILLINGS AREA INDIAN HEALTH BOARD

and attach hereto a duplicate original of the Articles of Amendment to the Articles of Incorporation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Montana, at Helena, the Capital, this 5th day of April A.D. 19 79

(GREAT SEAL)

Frank Murray
FRANK MURRAY
Secretary of State

Thomas Tucker
By Deputy

STATE OF MONTANA
FILED
APR 5 1979
FRANK MURRAY
SECRETARY OF STATE
By Kenneth W. Brown
Deputy Secretary

ARTICLES OF AMENDMENT
OF
ARTICLES OF INCORPORATION
OF
BILLINGS AREA INDIAN HEALTH BOARD

We, the undersigned, Daniel Foote, Chairman, and Carole Taylor, Secretary, of the above corporation, pursuant to the provisions of Section 15-2315 of the Revised Codes of the State of Montana, 1947, do hereby submit the following Articles of Amendment of the Articles of Incorporation of the Billings Area Indian Health Board, a nonprofit corporation:

I.

The name of the corporation is Billings Area Indian Health Board.

II.

The amendment adopted by the Board of Directors at a special meeting called for the purpose of amending the Articles of Incorporation is as follows:

"1. NAME: The name of this corporation is the MONTANA INDIAN HEALTH BOARD."

III.

The date of the adoption of the amendment by the Board of Directors was July 13, 1978, and such amendment received the vote of a majority of the Directors in office. There are no members entitled to vote thereon.

IV.

There were no further amendments.

DATED the 29th day of September, 1978.

BILLINGS AREA INDIAN HEALTH BOARD

BY: Daniel Foote
Daniel Foote, Chairman
President, Corporation

ATTEST:
Carole Taylor
Carole Taylor, Secretary

STATE OF MONTANA)
: ss.
County of Yellowstone)

DANIEL FOOTE AND CAROLE TAYLOR, being first duly sworn, say as follows:

That they are respective Chairman and Secretary of the Billings Area Indian Health Board, and are the persons who executed the foregoing Articles of Amendment of the Articles of Incorporation of said corporation; that they have read the foregoing Articles of Amendment and know the contents thereof, and that the same are true of their own knowledge.

Daniel Foote

x Carole Taylor

SUBSCRIBED AND SWORN to before me this _____ day of September, 1978.

_____
Notary Public for the State of Montana
Residing at Billings, Montana
My commission expires: _____

(SEAL)

Office of the Secretary of State

OF THE

STATE OF MONTANA

CERTIFICATE OF INCORPORATION

I, FRANK MURRAY, Secretary of State of the State of Montana, do hereby certify that duplicate originals of Articles of Incorporation for the incorporation of

BILLINGS AREA INDIAN HEALTH BOARD

duly executed pursuant to the provisions of Section 15-2329 of the Revised Codes of Montana, 1947, have been received in my office and are found to conform to law.

NOW, THEREFORE, I, FRANK MURRAY, as such Secretary of State, by virtue of the authority vested in me by law, hereby issue this Certificate of Incorporation to

BILLINGS AREA INDIAN HEALTH BOARD

and attach hereto a duplicate original of the Articles of Incorporation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Montana, at Helena, the Capital, this 10th day of May A.D. 19 74

(GREAT SEAL)

FRANK MURRAY
Secretary of State

By GAIL M. DeWALT
Chief Deputy

ARTICLES OF INCORPORATION

OF

BILLINGS AREA INDIAN HEALTH BOARD

-A NONPROFIT CORPORATION-

STATE OF MONTANA 209550
FILED
MAY 13 1974
FRANK MURRAY
SECRETARY OF STATE
By Thomas Tucker Deputy
Pd $20.00

The undersigned incorporator, for the purpose of forming a nonprofit corporation, pursuant to R.C.M., 1947, §§ 15-2301 et seq., sets forth the Articles of Incorporation in duplicate originals as follows:

1. NAME: The name of this Corporation is BILLINGS AREA INDIAN HEALTH BOARD.

2. DURATION: This Corporation shall have perpetual existence.

3. PURPOSES: The objects or purposes for which this Corporation is formed are:

(a) Generally, to conduct, engage in and carry on activities and programs which are organized exclusively for charitable and educational purposes, as such terms are defined in Internal Revenue Code (I.R.C.) § 501 (c)(3); and

(b) Specifically to evaluate the health needs of Montana and Wyoming Indians to undertake educational programs to assist Montana and Wyoming Indians to develop adequate health systems and to advise government and private agencies as to priorities, policies, and guidelines for the delivery of health services to Montana and Wyoming Indians; and

(c) To assist the Director and staff of the Billings Area Indian Health Service in carrying out their policy responsibilities in the care, treatment, hospitalization, and rehabilitation of Indian patients; and

(d) To do anything necessary, proper, advisable, or convenient for the accomplishment of the foregoing purposes, and to do all other things incidental thereto or connected therewith that are not

PETERSON AND HUNT
TELEPHONE 252-4671
TRANS-WESTERN LIFE BUILDING SUITE 302
404 NORTH 31ST STREET, BILLINGS, MONTANA 59101

forbidden by law, or by these Articles of Incorporation.

4. EARNINGS AND FUNDING: No part of the income, net earnings or funding contributions of this Corporation shall inure to the benefit of, or be distributable to, any member, director or officer of this Corporation or any other private individual provided that reasonable compensation may be paid for services rendered for the benefit of this Corporation, and reimbursement may be made for any expenses incurred for the benefit of this Corporation by any officer, director, agent or employee or any other person or corporation, pursuant to and upon authorization of the Board of Directors; and provided further, that no member, director or officer of this Corporation or any other private individual shall be entitled to share in any distribution of any of the corporate assets on dissolution of this Corporation or otherwise. No substantial part of the activities of this Corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation. This Corporation shall not participate or intervene in any political campaign on behalf or against any candidate for public office.

In the event of dissolution of this Corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of this Corporation, dispose of all the assets of this Corporation for the purposes of this Corporation or pay over or transfer all of the assets of this Corporation to one or more exempt organizations as described in IRC § 501 (c)(3).

Notwithstanding any other provision hereof, this Corporation shall not conduct or carry on any activities not permitted to be conducted or carried on by a charitable organization which is tax exempt under the provisions of IRC § 501 (c)(3).

5. BYLAWS: The bylaws shall be adopted by the Board of Directors. The power to alter, amend or repeal the bylaws or to adopt new bylaws shall be vested in the Board of Directors. The bylaws may contain provisions for the regulation and management of the affairs of this Corporation not inconsistent with the law or these Articles of Incorporation.

6. REGISTERED OFFICE AND AGENT: The address of the initial registered office of this Corporation is P. O. Box 2143, 3 7th Street West, Billings, Montana 59103, and the registered agent of this Corporation at that address is PAT LEFTHAND.

7. MEMBERS: This Corporation shall have no members but shall have a Board of Directors only.

8. BOARD OF DIRECTORS: The Board of Directors shall consist of eighteen (18) persons who need not be residents of the State of Montana. The initial number of Directors shall be eighteen (18) who shall serve until their successors are elected and qualify. The names and addresses of the persons who are to serve as the initial Directors are:

NAME	ADDRESS
Pat Lefthand	Box 2143, 3 7th Street West, Billings, Montana 59103
Lyman Young	Hays, Montana 59527
Mary Ewing	Box 44, Lame Deer, Montana 59043
Clara Dumontier	Box 214, Arlee, Montana 59821
Ada White	Box 1201, Crow Agency, Montana 59022
Wallace Iron	Box 414, Crow Agency, Montana 59022
Matthew Two Moons	Busby, Montana 59016
John Mitchell	Box Elder, Montana 59521
Joe DeMontigny	Box Elder, Montana 59521
Sylvia Roberts	Box 434, Wolf Point, Montana 59201
Lida Menz	Box 1027, Poplar, Montana 59255
Charles Gray	Harlem, Montana 59526
James Pogue	c/o Joint Bus. Council, Box 217, Ft. Washakie, Wyoming 82514
John Warren	Ft. Washakie, Wyoming 82514
Felix Groesbeck	Ft. Washakie, Wyoming 82514
Joseph Engavo, Sr.	Ft. Washakie, Wyoming 82514
Joe Show	Browning, Montana 59417
Marie Williamson	Browning, Montana 59417

9. INCORPORATOR: The name and address of the incorporator is:

NAME	ADDRESS
Pat Lefthand	2143, Billings, Montana 59103

IN WITNESS WHEREOF, the Articles of Incorporation have been signed this 3rd day of April, 1974.

Pat Lefthand

STATE OF MONTANA)
:ss.
County of Yellowstone)

On this day before me, the undersigned, a Notary Public for the State of Montana, personally appeared PAT LEFTHAND, known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Notarial Seal this 3rd day of April, 1974.

NOTARY PUBLIC for State of Montana
Residing at Billings, Montana
My Commission expires 9-17-76

BYLAWS

OF

BILLINGS AREA INDIAN HEALTH BOARD

-A NONPROFIT CORPORATION-

The Board of Directors of the Billings Area Indian Health Board, a Montana nonprofit Corporation, pursuant to the Revised Codes of Montana 1947, Chapter 15-2300, adopt the following bylaws:

OFFICES

1.00 PRINCIPAL OFFICE: The principal office of this corporation shall be situated at Billings, County of Yellowstone, Montana. The Board of Directors may change the principal office and may at any time designate other offices within or without the State of Montana.

BOARD OF DIRECTORS

2.00 MANAGEMENT AND RESIDENCE: The affairs of this Corporation shall be managed by its Board of Directors. The Board of Directors may hire a Program Manager, Administrative Officer, Administrative Assistant and Program Directors to carry out the directives and policies of the Board of Directors and further, to develop a plan of operations and spell out the functions of its employees. The Directors and/or alternates to the Board of Directors shall be residents of the States of Montana and Wyoming.

2.01 NUMBER OF DIRECTORS: The number of directors of this Corporation shall be eighteen (18) unless changed by amendment of the Articles of Incorporation with each Tribal Council having two (2) votes. The Board shall be composed of representatives from Indian Tribes who come within the jurisdiction of the Indian Reservations of the Billings Area: (1) Fort Belknap; (2) Crow; (3) Blackfeet; (4) Wind River; (5) Fort Peck; (6) Flathead; (7) Northern Cheyenne; (8) Rocky Boy. There shall be two (2) representatives from each reservation except the Wind River, which shall be entitled to four (4); two (2) for each Tribe.

2.02 APPOINTMENT OF DIRECTORS: The directors shall be appointed by the duly authorized Tribal Councils of each reservation in the Billings Area by resolution or by letter signed by the Tribal Chairman as authorized by the Tribal Council. The appointment shall be confirmed by a majority of the Board of Directors present and voting prior to the new membership voting. The appointments shall be on file with the Secretary of the Board of Directors after confirmation.

2.03 ALTERNATES FOR DIRECTORS: Alternates for directors may serve on the Board of Directors for any meeting provided that they are appointed in the same manner as provided for directors in 2.02. Alternates shall be subject to the same responsibilities and voting privileges as directors with the exception that they shall not be eligible to hold office.

2.04 DIRECTORS' TERMS: Directors' shall hold office on staggered terms as determined by their respective Tribal Councils.

2.05 VACANCIES: Vacancies on the Board of Directors shall occur as a result of one of the following: (a) a director resigns; (b) a director moves out of the area designated in 2.01 above; (c) a director's term expires; (d) a director becomes employed by the Indian Health Service and/or the U.S. Public Health Service; (e) a director becomes disabled or expires; (f) action deemed necessary is taken by the Tribal Council which appointed the director. Vacancies on the Board of Directors shall be filled by appointment from the same Tribe from which the vacancy occurred and such appointment shall be confirmed by the Board of Directors as provided in 2.02.

2.06 REGULAR MEETINGS: Regular meetings of the Board of Directors shall be held quarterly. Regular meetings shall be held at the principal office of this Corporation or at such other place within or without the State of Montana as the directors may determine, provided that, if said meetings are to be held at a place other than the regular meeting place, notice shall be given as provided in 2.07.

2.07 NOTICE FOR REGULAR MEETINGS: Notice of regular meetings of the Board of Directors shall be given two (2) weeks previously thereto by written notice delivered by certified and registered

mail to each director at his address as shown by the records of this Corporation.

2.08 QUORUM: Ten (10) or more directors and/or alternates duly appointed as designated herein and present at a meeting shall constitute a quorum for the transaction of business by the Board of Directors. Every act or decision done or made by a majority of the directors and/or alternates present at a meeting shall be an official act of the Board of Directors, unless a greater number be required by law.

2.09 LACK OF QUORUM: If a quorum as determined in 2.08 above is not present within one (1) hour after the time scheduled for a meeting, the Chairman shall recess said meeting for not more than four (4) hours to allow for attempts to gain a quorum. After the allotted four (4) hours have transpired and a quorum is still not present the meeting shall be adjourned until the next regular meeting or until the next day.

2.10 VOTING: Only directors and/or alternates, as designated herein, present at the meeting shall be allowed an official vote at any meeting of the Board of Directors. Each Tribe shall have a maximum of two (2) voting directors and/or alternates at any official meeting of the Billings Area Indian Health Board.

2.11 SPECIAL MEETINGS: Special meetings of the Board of Directors may be called by or at the request of the Chairman or any three directors and shall be held at the principal office of this Corporation.

2.12 NOTICE FOR SPECIAL MEETINGS: Notice of any special meetings of the Board of Directors shall be given not more than thirty (30) nor less than fourteen (14) days previously thereto by written notice delivered by certified and registered mail or telegram to each director at his address as shown by the records of this Corporation.

OFFICERS

3.00 DESIGNATION: The officers of this Corporation shall be a Chairman, a Vice-Chairman, a Secretary-Treasurer, a Parliamentarian and a Member-at-Large.

3.01 ELECTION & TERM OF OFFICERS: Only directors as designated herein shall be eligible to held office within the Board of Directors. Officers shall be elected by the Directors and/or designated alternates of the Board of Directors and each officer elected shall serve for a term of two (2) years. Officers may serve successive terms.

3.02 REMOVAL OF OFFICERS: Any officer, in his capacity as an officer, may be removed at any time for cause by vote of a

majority of the directors and/or alternates then serving on the Board of Directors and present at the meeting at which such a vote is taken.

3.03 FILLING VACANCIES: A vacancy in any office because of death, resignation, removal, disqualification, or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

3.04 CHAIRMAN: The Chairman shall preside at all meetings of the Board of Directors at which he/she is present. The Chairman shall have authority to sign all documents requiring a signature from the Board of Directors, subject to any actions taken at any official Board of Directors' meeting. The Chairman shall have the option of voting on all matters brought before the Board of Directors.

3.05 VICE CHAIRMAN: In the absence or disability of the Chairman, the Vice-Chairman shall perform all the duties of the Chairman and when so acting shall have all the powers of, and be subject to all the restrictions placed upon the Chairman.

3.06 SECRETARY-TREASURER: The Secretary-Treasurer shall have the responsibility of monitoring: (a) the production of the minutes of all meetings of the Board of Directors; (b) all such correspondence as deemed necessary by the Board of Directors; and (c) all monetary concerns relating to this corporation and its Board of Directors as deemed necessary by the Board of Directors. The Secretary shall

have available at every official meeting of the Board of Directors all resolutions and other documents relating to the status of all directors and/or alternates to the Board of Directors. The Secretary shall have the responsibility of contacting those Tribal Councils whose representatives are not attending meetings regularly.

3.07 PARLIAMENTARIAN: The Parliamentarian shall advise the presiding officer to ensure that (a) the agenda and other procedures as determined by the Board of Directors are adhered to; (b) the appointments of the directors and/or alternates to the Board of Directors are in accordance with the provisions as designated herein; and (c) a quorum as designated herein is present for the official transaction of business by the Board of Directors. The Parliamentarian shall admit and dismiss such individuals to and from meetings as deemed appropriate or necessary by the Board of Directors.

3.08 MEMBER-AT-LARGE: The Member-at-Large shall be appointed by the Chairman at each quarterly meeting.

3.09 EXECUTIVE COMMITTEE: The Executive Committee shall consist of the officers: Chairman, Vice-Chairman, Secretary-Treasurer, Parliamentarian and Member-At-Large. The prime functions of this committee shall be the review and research of policies, programs, priorities, resources and other matters for the purpose of

preparing recommendations to the Board of Directors for final disposition. The Executive Committee shall have the authority and responsibility of assembling an agenda for the meetings of the Board of Directors. The Executive Committee shall serve as a Grievance Committee for the staff on all program and personnel problems.

3.10 OTHER COMMITTEES: The Board of Directors may appoint committees for special purposes whose functions will cease when the purpose for which they have been formed has been accomplished. All committees will function only as directed by the Board of Directors.

CONTRACTS, CHECKS, DEPOSITS & FUNDS

4.00 CONTRACTS AND INSTRUMENTS: The Board of Directors shall authorize the Chairman, Vice-Chairman and the Secretary-Treasurer of this Corporation to enter into any contract or execute and deliver any instrument in the name of and/or on behalf of the Corporation.

4.01 CHECKS AND DRAFTS: All checks, drafts or other orders for payment of money, notes or other evidence of indebtedness issued in the name of or payable to this Corporation, shall be signed or endorsed by such person or persons and in such manner as shall be determined by resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such

instruments shall be signed by the Secretary-Treasurer and countersigned by the Chairman or the Vice-Chairman of the Board of Directors for the Corporation.

4.02 DEPOSITORY: All funds of this Corporation shall be deposited to the credit of this Corporation in such banks, trust companies or other depositories as the Board of Directors may select.

4.03 GIFTS AND CONTRIBUTIONS: The Board of Directors may accept on behalf of this Corporation any contribution, gift, bequest or device for the purpose of this Corporation.

MISCELLANEOUS PROVISIONS

5.00 FISCAL YEAR: The fiscal year of this Corporation shall begin on the first day of October of each year and end at midnight on the thirtieth (30th) day of September.

5.01 CORPORATE SEAL: The corporate seal shall be in the following form: BAIHB, Inc. - Corporate Seal - State of Montana.

5.02 WAIVER OF NOTICE: Whenever any notice is required to be given under the provisions of the Revised Codes of Montana, 1947, 15-2301 et cetera sequential, or under the provisions of the Articles of Incorporation or the bylaws of this Corporation, a waiver thereof in writing signed by the persons entitled to such

notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

5.03 REIMBURSEMENT OF COSTS AND EXPENSES: All officers, directors and alternates to the Board of Directors shall be reimbursed for costs and expenses incurred in work performed in furthering the purposes of this Corporation as authorized by the Board of Directors, but shall receive no salary or other remuneration. Officers, directors and/or alternates shall not be eligible for per diem payments for those days in which they did not remain in attendance for the full duration of that day's meeting, unless a waiver or exception is authorized by a majority vote of those directors and/or alternates at such meeting.

5.04 AMENDMENT OF BYLAWS: These bylaws may be altered, amended, or repealed and new bylaws may be adopted by a majority of the directors present at any regular meeting or at any special meeting.

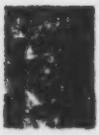
DATED this 21st day of July, 1977

_____
Chairman, BAIHB

ATTEST:

_____
Secretary-Treasurer

RESOLUTIONS OF SUPPORT FOR THE MONTANA INDIAN HEALTH BOARD



CHIEF BLACK COAL

ARAPAHOE TRIBE
Box 217
Ft. Washakie, Wyoming 82514

CHIEF BLACK COAL

RECEIVED
APR 12 1982
HEALTH CAREERS
RECRUITMENT PROGRAM

April 9, 1982

Ms. Bailey
Health Careers Recruitment Program
1215 24th St. West-Suite 210
Billings, MT. 59102

Dear Ms. Bailey:

The Arapahoe Business Council meet on April 2, 1982 and the support and endorsement of the Montana Indian Health Board was discussed. It is the feelings of the Arapahoe Business Council that should support and endorsement of the Montana Indian Health Board be rendered that the health problems and other pertinent problems that affect the Wind River Indian Reservation be considered as well as those of the Montana Tribes.

The Arapahoe Business Council reached the decision that they will support and endorse the fund raising activities that are being pursued by the Montana Indian Health Board, It is our hopes that these fund raising activities not have an affect on the budget of those funds allocated to the Wind River Indian Reservation. Should any questions arise please feel free in contacting our Business Manager, Richard Small, at (307) 255-8391, Ext. #5. Thank you.

Sincerely yours,

Joseph Oldman
Arapahoe Tribal Chairman

JO/cyb

cc: Robert LaFrombois
Asst. Area Director

THE BLACKFEET TRIBE

OF THE BLACKFEET INDIAN RESERVATION

BROWNING, MONTANA 59417

EXECUTIVE COMMITTEE
EARL OLD PERSON, CHAIRMAN
DANIEL L. GILHAM SR., VICE-CHAIRMAN
CHARLES CONNELLY #1, SECRETARY
ELOUISE C. COBELL, TREASURER

TRIBAL COUNCIL
EARL OLD PERSON
DANIEL L. GILHAM SR.
CHARLES CONNELLY #1
LELAND GROUND
ARCHIE ST. GODDARD
LEONARD MOUNTAIN CHIEF
GEORGE KICKING WOMAN
JERRY SHOW
PHILIP M. RATTLER JR.

March 22, 1982

RECEIVED
MAR 26 1982
MONTANA INDIAN
HEALTH BOARD

Chairperson
Montana Indian Health Board
1215 24th St. West - Suite 210
Billings, MT 59102

Dear Chairperson:

This letter is in response to your letter requesting a support letter for continuation funding for the Montana Indian Health Board. The Blackfeet Tribe is desirous of supporting this organization with certain stipulations as listed:

1. Providing that his organization is not in competition for funds with the participating Tribes.

2. That this organization request 2% of the Area Office Budget for operational funds.

Attached, you will find a resolution of support, and if your office has any further questions, feel free to contact our office.

Sincerely,

Earl Old Person, Chairman
Blackfeet Tribal Council

Attachment

/cw

THE BLACKFEET TRIBE

OF THE BLACKFEET INDIAN RESERVATION

BROWNING, MONTANA 59417

RECEIVED
MAR 26 1982
MONTANA INDIAN HEALTH BOARD

EXECUTIVE COMMITTEE
EARL OLD PERSON CHAIRMAN
DANIEL L GILHAM SR VICE CHAIRMAN
CHARLES CONNELLY VI SECRETARY
ELOUISE C COBELL TREASURER

TRIBAL COUNCIL
EARL OLD PERSON
DANIEL L GILHAM SR
CHARLES CONNELLY VI
LELAND GROUND
ARCHIE ST GODDARD
LEONARD MOUNTAIN CHIEF
GEORGE KICKING WOMAN
JERRY SHOW
PHILIP M RATTLER JR

RESOLUTION

Number: 267-82

WHEREAS: The Blackfeet Tribe of the Blackfeet Indian Reservation, an Indian Chartered Federal Corporation, incorporated under the Act of 18 June 1934 (48 Statute 904), and the Blackfeet Tribal Business Council is the duly elected body empowered to handle and discharge the business of the Blackfeet Tribe of the Blackfeet Indian Reservation, an Indian Chartered Federal Corporation;

WHEREAS: The Blackfeet Tribal Business Council being the duly elected body empowered to handle and discharge the business of the Blackfeet Tribe of the Blackfeet Indian Reservation is responsible and empowered to assure qualitative health delivery service to the Blackfeet people;

WHEREAS: The Blackfeet Tribal Business Council is responsible for the administration of all existing health programs on the Blackfeet Indian Reservation;

THEREFORE BE IT RESOLVED: The Blackfeet Tribe hereby endorses and supports the efforts of the Montana Indian Health Board to secure continuation of funds under the Indian Health Service, at the Area Level or other appropriate sources, and not to be in competition for funds with the participating tribes of the M.I.H.B.

BE IT FURTHER RESOLVED: That the Montana Indian Health Board request two (2%) percent of the Billings Area Office Budget for operation.

THE BLACKFEET TRIBE OF THE
BLACKFEET INDIAN RESERVATION

Earl Old Person, Chairman

ATTEST:

Charles J. Connelly, Secretary

CERTIFICATION

I hereby certify that the foregoing resolution was adopted by the Blackfeet Tribal Business Council in duly called, noticed and convened Special Session assembled for business the 9th day of March, 1982 with Six (6) members present to constitute a quorum and by a vote of Six (6) members For and None Opposed.

(CORPORATE SEAL)

Charles J. Connelly, Secretary
Blackfeet Tribal Business Council

CROW TRIBAL COUNCIL

CROW TRIBE OF INDIANS

CROW AGENCY, MONTANA 59022

Crow Country

DONALD STEWART SR., CHAIRMAN
DANETTA FALLS DOWN, VICE-CHAIRMAN
THEODORE (TED) HOGAN, SECRETARY
CHARLES JEFFERSON, VICE-SECRETARY

October 1, 1982

RECEIVED

OCT 12 1982

MONTANA INDIAN HEALTH BOARD

Montana Indian Health Board
1215 - 24th Street West, Suite 110
Billings, Montana 59102

Attention: Lasona Bailey

Dear Ms. Bailey:

This will serve as a letter of Support from the Crow Tribe in your efforts to seek future funding for the Montana Indian Health Board.

In accordance with the above, I hereby endorse and support the efforts of the Montana Indian Health Board to secure continuation of funds under the Indian Health Service at the area level or other appropriate sources. Resolution will follow.

Sincerely,

Donald Stewart, Sr.
Chairman
Crow Tribal Council

Attest:

Noted and Forwarded:

Date 10-8-82

Theodore J. Hogan, Secretary
Crow Tribal Council

THE CONFEDERATED SALISH AND KOOTENAI TRIBES
OF THE FLATHEAD RESERVATION

FLATHEAD NATION

Box 278
Pablo, Montana 59855
(406) 675-2700

Fred Houle, Jr. - Executive Secretary
Vern F. Clairmont - Executive Treasurer
Baptiste McDonald - Sergeant-at-Arms

RECEIVED
MAR 22 1982
MONTANA INDIAN HEALTH BOARD

March 11, 1982

TRIBAL COUNCIL MEMBERS
Thomas E. Pablo - Chairman
Joseph "Joe Dog" Felsman - Vice-Chairman
Victor L. Singer - Tribal Secretary
Robert L. McCrea - Tribal Treasurer

Al Hewankorn
John McClure
E.W. Morigeau
Sonny Morigeau
Noel Pichette
James H. Steele

Refer to:

Tribal Health Department
P.O. Box 340
St. Ignatius, MT 59865

Jessie James, Chairperson
Montana Indian Health Board
Suite 210
1215 24th St. West
Billings, Montana 59102

Dear Jessie,

In response to your solicitation for letters of support for Montana Indian Health Board efforts to secure funding from the Indian Health Service the Health Board for the Confederated Salish & Kootenai Tribes has taken the following position.

While our Health Board is in full support of establishing a strong Montana Indian Health Board it must be understood that first priority for Tribal Management funding should be for local Tribal Management functions. It is our understanding that the Montana Indian Health Board is seeking Tribal Management funds which are crucial to the continuation of local Tribal efforts. Consequently we cannot support MIHB efforts to secure funding which would result in weakening Tribal initiatives in health care.

Support will be given to MIHB for securing funding from other sources Tribes are not eligible for. However, to avoid any future conflicts it is hoped that the goals and objectives pursued by the MIHB will in all cases be aimed at supporting local Tribal efforts.

Sincerely,

Dorothy Webster

Dorothy Webster
Chairperson, Tribal Health Board

RECEIVED
MAR 25 1982
MONTANA INDIAN HEALTH BOARD

TRIBAL COUNCIL OF THE NORTHERN CHEYENNE
NORTHERN CHEYENNE RESERVATION
LAME DEER, MONTANA

RESOLUTION NO. 95(82)

A RESOLUTION OF THE NORTHERN CHEYENNE TRIBAL COUNCIL ENDORSING AND SUPPORTING THE EFFORTS OF THE MONTANA INDIAN HEALTH BOARDS' EFFORTS TO SECURE CONTINUATION FUNDING UNDER THE INDIAN HEALTH SERVICE AT THE AREA LEVEL OF OTHER APPROPRIATE SOURCE.

WHEREAS, the Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, an Indian Chartered Federal Corporation, incorporated under the Act of June 18, 1934 as the Northern Cheyenne Tribal Council as a duly empowered body elected by the Tribal members to handle and discharge the business of the Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, an Indian Chartered Federal Corporation; and,

WHEREAS, the Northern Cheyenne Tribal Council being the duly elected body empowered to handle and discharge the business of the Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation is responsible and empowereed to assure qualitative and quantitative health delivery services of the Northern Cheyenne People; and,

WHEREAS, the Northern Cheyenne Tribe is a participating member of the Montana Indian Health Board; and,

WHEREAS, the Montana Indian Health Board is presently seeking continued funding under the Billings Area Indian Health Service; now,

THEREFORE BE IT RESOLVED that the Northern Cheyenne Tribal Council does hereby endorse and support the efforts of the Montana Indian Health Boards' efforts to secure continuation funding under the Indian Health Service at the Area Level of other appropriate source.

PASSED, ADOPTED AND APPROVED by the Northern Cheyenne Tribal Council by 13 votes for passage and adoption and 0 votes against passage and adoption this 12th day of March, 1982.

Allen Rowland, President
NOrthern Cheyenne Tribal Council

ATTEST:

Linda M. Bahr, SEcretary
NOrthern Cheyenne Tribal Council

RECEIVED
MAY 7 1982
MONTANA INDIAN HEALTH BOARD

Resolution No. 64-82

Fort Belknap Community Council

Montana Indian Health Board Membership/Delegates

WHEREAS, the Fort Belknap Indian Community Council is the governing body of the Gros Ventre and Assiniboine Tribes of the Fort Belknap Indian Community, Fort Belknap Indian Reservation, Montana, by the authority of the Constitution and By-Laws of the Fort Belknap Tribes approved on the 13th day of December, 1935, and

WHEREAS, under the Constitution and By-Laws of the Fort Belknap Indian Community, the Community Council is charged with the duty of protecting the health, security and general welfare of the Fort Belknap Indian Community, and

WHEREAS, The Montana Indian Health Board has been established to advocate on behalf of the Montana Tribes for improved health care in all areas, and

WHEREAS, The Montana Indian Health Board is currently being considered for continuation of funding for FY 1982 from the Indian Health Service, and

WHEREAS, The funding for Montana Indian Health Board comes from non-recurring funds, now

THEREFORE BE IT RESOLVED, That the Fort Belknap Indian Community Council re-affirms its membership in and support of the Montana Indian Health Board, and

BE IT FURTHER RESOLVED, That Donovan Archambault is the appointed official delegate to serve on the Montana Indian Health Board and Gertrude Werk is the second delegate.

ATTEST:

Henry Brockie, Sr. - President

George H. Snell, Jr. - Secretary

CERTIFICATION

I, the undersigned, as Secretary of the Fort Belknap Indian Community Council of the Fort Belknap Reservation, Montana, do hereby certify that the Fort Belknap Community Council is composed of 12 members of whom 9 members, constituting a quorum were present at a meeting hereof, duly and regularly called, noticed, convened and held this 3rd day of May, 1982; and that the foregoing resolution was adopted by the affirmative vote of 7 for; 0 opposed; 1 temp. absent; 1 not voting; 3 absent; and that the said resolution has not been rescinded in any way.

DATED: 5-4-82

George H. Snell, Jr. - Secretary

FORT BELKNAP INDIAN COMMUNITY
Tribal Government

FORT BELKNAP AGENCY, HARLEM, MONTANA
Address

The Chippewa Cree Tribe of the Rocky Boy's Reservation

Phone 395-4478 or 395-4727 · Rocky Boy Route · Box Elder, Montana 59521

RECEIVED

MAR 8 1982

MONTANA INDIAN HEALTH BOARD

Montana Indian Health Board
1215 - 24th Street West, Suite 210
Billings, Montana 59102

Attention: Lazona Bailey

Dear Ms. Bailey:

This will serve as a letter of Support from the Chippewa-Cree Tribe in your efforts to seek future funding for the MIHB.

In accordance with the above, I hereby endorse and support the efforts of the Montana Indian Health Board to secure continuation of funds under the Indian Health Service at the area level or other appropriate sources. Resolution will follow.

Sincerely,

Board of Health
Chairman

Attest:

Noted and Forwarded:

Date: 2/26/82

Tribal Chairman, Name, and Tribe

JH/pgp

The Chippewa Cree Tribe of the Rocky Boy's Reservation

Phone 395-4478 or 395-4727 · Rocky Boy Route · Box Elder, Montana 59521

A RESOLUTION
MONTANA INDIAN HEALTH BOARD NO: 10-82

WHEREAS, THE CHIPPEWA CREE TRIBAL BUSINESS COMMITTEE IS THE GOVERNING BODY OF THE CHIPPEWA CREE TRIBE OF THE ROCKY BOY'S INDIAN RESERVATION, BY THE AUTHORITY OF THE CONSTITUTION AND BY-LAWS OF THE CHIPPEWA CREE TRIBE, APPROVED ON THE 23RD DAY OF NOVEMBER 1935, AND,

WHEREAS, the Rocky Boy Health Board is a recognized sub-committee of the Chippewa Cree Tribal Business Committee by tribal resolution #10A-74 and has been delegated full authority for the administrative and supervisory responsibilities of all on-going and future health related projects, and,

WHEREAS, the Chippewa Cree Tribe of the Rocky Boy's Reservation and Indian Chartered Federal Corporation, incorporated under the Act of the Constitution and By-laws of the Chippewa Cree Tribe, approved on the 23rd day of November, 1935, as the Chippewa Cree Tribal Council, as a duly empowered body elected by the tribal members to handle and discharge business of the Chippewa Cree Tribe of the Rocky Boy's Indian Reservation, is responsible and empowered to assure qualitative and quantitive health delivery services of the Chippewa Cree people, and,

WHEREAS, the Chippewa Cree Tribe is a participating member of the Montana Indian Health Board, and,

WHEREAS, the Montana Indian Health Board is presently seeking continued funding under the Billings Area Indian Health Service.

THEREFORE BE IT RESOLVED, that the Chippewa Cree Business Committee does hereby endorse and support the efforts of the Montana Indian Health Board's efforts to secure continuation funding under the Indian Health Service at the Area Level or other appropriate source.

CERTIFICATION

I, THE UNDERSIGNED, AS CHAIRMAN OF THE CHIPPEWA CREE TRIBE, HEREBY CERTIFY THAT THE CHIPPEWA CREE BUSINESS COMMITTEE IS COMPOSED OF NINE MEMBERS, OF WHOM 8 MEMBERS, CONSTITUTING A QUORUM, WERE PRESENT AT THE MEETING THEREOF, DULY AND REGULARLY CALLED, NOTIFIED, CONVENED, AND HELD THIS DAY OF 23rd MONTH OF Feb., 1982, AND THAT THE FOREGOING RESOLUTION WAS DULY ADOPTED BY THE AFFIRMATIVE VOTE OF 7 AGAINST AND 0 MEMBERS FOR AND THAT THIS RESOLUTION HAD NOT BEEN RESCINDED OR AMENDED IN ANYWAY.

CHAIRMAN, CHIPPEWA CREE BUSINESS COMM.

SECRETARY, BUSINESS COMMITTEE

CHAIRMAN, ROCKY BOY HEALTH BOARD

APPROVED ✓ DISAPPROVED

RECEIVED
MAR 24 1982
MONTANA INDIAN
HEALTH BOARD

RESOLUTIONS OF SUPPORT FOR THE

HEALTH CAREERS RECRUITMENT PROGRAM

CHIEF BLACK COAL

ARAPAHOE TRIBE
Box 217
Ft. Washakie, Wyoming 82514

CHIEF BLACK COAL

March 19, 1982

RECEIVED

APR 9 1982

HEALTH CAREERS
RECRUITMENT PROJECT

Health Careers Recruitment Program
1215 24th St. West - Suite 210
Billings, MT 59102

Dear Mse. Bailey:

In review of your request for support and endorsement for the Health Careers Recruitment Program. It is the Northern Arapahoe Business Council's decision that the existence of the Health Career's Program is necessary, in that the Northern Arapahoe Tribe is an advocate of higher education. The Northern Arapahoe Business Council does in fact endorse and support the request for funding for the Health Career's Program. Should additional information be desired, please feel free in calling our Arapahoe Business Manager, Richard D. Small at (30[illegible] [illegible]2391, Ext. 5. Thank you.

Sincerely,

Joseph Oldman

Joseph Oldman, Chairman
Arapahoe Business Council

RECEIVED
APR 9 1982
HEALTH CAREERS
RECRUITMENT PROGRAM

RESOLUTION OF THE
NORTHERN ARAPAHOE BUSINESS COUNCIL
WIND RIVER INDIAN RESERVATION
FORT WASHAKIE, WYOMING 82514

Resolution No. 4986

WHEREAS, the Northern Arapahoe Business Council is elected by the enrolled members of the Northern Arapahoe Tribe to conduct business on their behalf and for their well being; and

WHEREAS, the Northern Arapahoe Tribe is an advocate of higher education for its people; and

WHEREAS, the Health Careers Recruitment Program does promote higher education, specifically in the health fields; and

WHEREAS, the Northern Arapahoe Business Council, on behalf of the Northern Arapahoe Tribe, does endorse and support the Health Careers Recruitment Program and its application for P. L. 94-484 funding from the Health Resources Administration at Hyattsville, Maryland.

NOW, THEREFORE BE IT RESOLVED, the Northern Arapahoe Business Council does support and endorse the Health Careers Recruitment Program at Billings, Montana.

BE IT FURTHER RESOLVED, that the Northern Arapahoe Business Council requests that the P. L. 94-484, Health Resource Administration in Hyattsville, Maryland approve said grant application.

CERTIFICATION

I, the undersigned, as Chairman of the Northern Arapahoe Business Council hereby certify that the Arapahoe Business Council consists of six (6) members and that at a meeting of the Arapahoe Business Council held on April 2, , 1982, the foregoing resolution was adopted by a vote of Five (5) Affirmative, Zero (0) Against, and that the foregoing resolution has not been rescinded or amended in any way. Chairman voting.

Done at Fort Washakie, Wyoming this 2nd day of April , 1982.

Eugene Ridgely, Sr., Co-Chairman
Northern Arapahoe Business Council

ATTEST:

Secretary

CROW TRIBAL COUNCIL

Crow Country

October 1, 1982

CROW AGENCY, MONTANA 59022

DONALD A. STEWART SR., CHAIRMAN
DANETTA FALLS DOWN, VICE-CHAIRMAN
THEODORE (TED) HOGAN, SECRETARY
CHARLES JEFFERSON, VICE-SECRETARY

RECEIVED
OCT 12 1982
HEALTH CAREERS
RECRUITMENT PROG...

Health Careers Recruitment Program
1215 - 24th Street West, Suite 110
Billings, Montana 59102

Attention: Lazona Bailey

Dear Ms. Bailey:

This will serve as a letter of Support from the Crow Tribe in your efforts to seek future funding for the Health Careers Recruitment Program.

In accordance with the above, I hereby endorse and support the efforts of the Health Careers Recruitment Program to secure continuation of funds under Health and Human Services or other appropriate sources.

Resolution will follow:

Sincerely,

Donald A. Stewart Sr., Chairman
Crow Tribal Council

Attest:

Noted and Forwarded:

Date 10-8-82

Theodore J. Hogan, Secretary
Crow Tribal Council

Fort Belknap Community Council

FORT BELKNAP EDUCATION DEPARTMENT

April 9, 1982

RECEIVED

APR 13 1982

HEALTH CAREERS
RECRUITMENT PROGRAM

Lazona Baily, Project Supervisor
Health Careers Recruitment Program
1215 24th Street West, Suite 210
Billings, Montana 59102

Dear Lazona:

Enclosed is the Fort Belknap Indian Community Council's resolution number 44-82 in regards to the support and endorsement of the Montana and Wyoming Indian Health Careers Recruitment Program to secure continued funding.

I would like to wish you the best of luck and success at refunding this very viable program that you currently offer to Montana and Wyoming Indian students. I heard a lot of fine comments about your program and hopefully the current administration will continue this program in the future.

If I can be of further assistance, please do not hesitate in calling or writing my office.

Sincerely,

Robert J. Swan, Director
Fort Belknap Education Department
Box 39
Harlem, Montana 59526

Enclosure:

Fort Belknap Community Council

FORT BELKNAP EDUCATION DEPARTMENT

[illegible]

RECEIVED

APR 13 1982

HEALTH CAREERS
RECRUITMENT PROGRAM

Resolution No. 4/4-82

Health Careers Program

WHEREAS, the Fort Belknap Indian Community Council is the governing body of the Gros Ventre and Assiniboine Tribes of the Fort Belknap Indian Community, Fort Belknap Indian Reservation, Montana by the authority of the Constitution and Bylaws of the Fort Belknap Tribes approved on the 13th day of December, 1935 and

WHEREAS, under the Constitution and Bylaws of the Fort Belknap Indian Community, the Community Council is charged with the duty of protecting the health, security and general welfare of the Fort Belknap Indian Community.

WHEREAS, the Fort Belknap Indian Community Council is a participating member of the Montana and Wyoming Indian Health Careers Recruitment Program.

WHEREAS, the Montana and Wyoming Indian Health Careers Recruitment Program is presently seeking continued funding under P.L. 94-484 from Health Resources Administration out of Hyattsville, Maryland.

THEREFORE BE IT RESOLVED THAT: the Fort Belknap Indian Community Council does hereby endorse and support the efforts of the Montana and Wyoming Indian Health Careers Recruitment Program to secure continued funding.

ATTEST:

George H. Snell, Secretary

Henry Brockie, Sr., Chairman

CERTIFICATION

I, the undersigned, as Secretary of the Fort Belknap Indian Community Council of the Fort Belknap Indian Reservation, Montana, do hereby certify that the Fort Belknap Indian Community Council is composed of 12 members of whom 10 members, constituting a quorum were present at a meeting thereof, duly and regularly called, noticed, convened and held this 5th day of April, 1982, and that the foregoing resolution was adopted by the affirmative vote of 9 for; 0 opposed; 1 not voting; 2 absent; and that the said resolution has not been rescinded in any way.

DATED: 4-5-82

George H. Small, Secretary

FORT BELKNAP INDIAN COMMUNITY
Tribal Government

FORT BELKNAP AGENCY, HARLEM, MONTANA
Address

RESOLUTION #1573-82-11 TRIBAL GOVERNMENT

WHEREAS, the Fort Peck Tribal Executive Board is the duly elected body representing the Assiniboine and Sioux Tribes of the Fort Peck Reservation and is empowered to act in behalf of the Tribes. All actions shall be adherent to provisions set forth in the 1960 Constitution and By-Laws and Public Law #83-449, and

WHEREAS, there is a HEW Committee recommendation for the Ft Peck Tribes to fully support the Montana-Wyoming Health Careers Recruitment Program, now

THEREFORE BE IT RESOLVED, that the Tribal Executive Board does hereby approve of the above recommendation.

C E R T I F I C A T I O N

I, the undersigned Secretary Accountant of the Tribal Executive Board of the Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, hereby certify that the Tribal Executive Board is composed of 12 voting members of whom 9 constituting a quorum were present at a Regular meeting duly called and convened this 22nd day of November, 1982, that the foregoing resolution was duly adopted at such meeting by the affirmative vote of 9.

Myrna Greufe, Secretary

APPROVED:

Joseph Red Thunder, Vice Chairman
Fort Peck Tribal Executive Board

Superintendent, Fort Peck Agency

RECEIVED
MAY 19 1983
HEALTH CAREERS
RECRUITMENT

RECEIVED
MAR 25 1982

TRIBAL COUNCIL OF THE NORTHERN CHEYENNE
NORTHERN CHEYENNE RESERVATION
LAME DEER, MONTANA

RESOLUTION NO. 109(82)

A RESOLUTION OF THE NORTHERN CHEYENNE TRIBAL COUNCIL ENDORSING AND SUPPORTING THE EFFORTS OF THE MONTANA AND WYOMING INDIAN HEALTH CAREERS RECRUITMENT PROGRAM TO SECURE CONTINUED FUNDING.

WHEREAS, the Northern Cheyenne Tribe of the Northern Cheyenne Reservation, an Indian Chartered Federal Corporation, incorporated under the Act of June 18, 1934 as the Northern Cheyenne Tribal Council as a duly empowered body elected by the Tribal members to handle and discharge the business of the Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, an Indian Chartered Federal Corporation; and,

WHEREAS, the Northern Cheyenne Tribal Council being the duly elected body empowered to handle and discharge the business of the Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation is responsible and empowered to assure qualitative and quantitative health delivery services of the Northern Cheyenne people; and,

WHEREAS, the Northern Cheyenne Tribe is a participating member of the Montana and Wyoming Indian Health Careers Recruitment Program; and,

WHEREAS, the Montana and Wyoming Indian Health Careers Recruitment Program is presently seeking continued funding under P.L. 94-484 from Health Resources Administration out of Hyattsville, Maryland; now,

THEREFORE BE IT RESOLVED that the Northern Cheyenne Tribal Council does hereby endorse and support the efforts of the Montana and Wyoming Indian Health Careers Recruitment Program to secure continued funding.

PASSED, ADOPTED AND APPROVED by the Northern Cheyenne Tribal Council by 16 votes for passage and adoption and 0 votes against passage and adoption this 22nd day of March, 1982.

for Allen Rowland, President
Northern Cheyenne Tribal Council

ATTEST:

Linda M. Bahr, Secretary
Northern Cheyenne Tribal Council

Montana Inter-Tribal Policy Board

2303 Grand Ave., Suite 5 • Billings, MT 59102 • (406) 652-3113

MEMBER TRIBES

Blackfeet
Crow
Flathead
Fort Belknap
Fort Peck
Little Shell
Northern Cheyenne
Rocky Boy

January 13, 1983

Health Careers Recruitment Program
Attention: Lazona Bailey
1215 24th Street West, Suite 110
Billings, Montana 59102

Dear Ms. Bailey:

This will serve as a letter of Support from the Montana Inter-Tribal Policy Board in your efforts to seek future funding for the Health Careers Recruitment Program.

In accordance with the above, I hereby endorse and support the efforts of the Health Careers Recruitment Program to secure continuation of funds under Health and Human Services or other appropriate sources.

Sincerely,

Caleb Shields
Chairman, MITPB

CS/ctp

RECEIVED
JAN 19 1983
HEALTH CAREERS
RECRUITMENT PROGRAM

Senator MELCHER. Do you want to give us a lowdown on Fort Belknap?

Mr. ARCHANBAULT. Yes. This is on behalf of the tribes at Fort Belknap, and I am here at the request of the tribal chairman. He asked me to express my thanks on behalf of he and the tribe for allowing us to be here.

I would like to read a brief statement, then I will submit the written testimony.

Senator MELCHER. Yes, that would be fine.

Mr. ARCHANBAULT. The United States has an impressive history for taking the side of the underdog on issues specific to human rights, dignity and prosperity. Its intervention in the name of equality for the downtrodden nations of the world has fostered a vocabulary that has added a few pages to Old Webster: altruistic, humanistic, humanism are but a few of these words.

The utter disdain that the administration has toward the first people of this country shows the true color and meaning of the rhetoric that so readily flows in its denunciation of rulers of nations that abuse their people. At no time in history has a proud race of people been so brutalized, deprecated, and maligned as the first Americans, for such a long period of time, by so many rulers. It would appear that the sanctimonious attitude of many of your colleagues and the many administrations that have ruled this country would diminish somewhat through the years, but that is not the case. Bodies come and go, but the attitude remains; callowness, philistinism, and negativism prevail; each pointing a finger at the next session, all blaming the Indian for his predicament, not realizing or trying to understand why the situation exists.

Although much legislation has been enacted to negate the preconceptions that most people have of the American Indian, he still cannot leave the reservation and borrow money from the bank, receive equal consideration for employment, participate in other county, State and federally funded programs, for the most part, without experiencing all the prejudice and ridicule that exists in the American society. The Indian is still experiencing the mentality exhibited toward the Japanese during and after the Second World War. The Japanese in this country today are afforded far more social and economic privileges than the American Indian. The Indian wars have been over for 100 years.

The unemployment rate on the Fort Belknap Reservation has exceeded 70 percent since 1980. The mean rate for the past 10 years has hovered at 50 percent. The mean income level for the reservation is currently $4,500 as compared to $15,000 nationally and $14,000 for the State of Montana. This information was taken from the Montana State Economic Development Office, U.S. Census. It would seem that the United States Government would bring about some parity in the distribution of resources and social equity within her own realm before venturing forth with a pointed finger.

Central to the administration's budget and its blind betrayal of a trust responsibility which exists by virtue of signed contracts or treaties with Indian tribes is the need for adequate health delivery to Indians.

This is not the case. The new budget exhibits the true feeling of human rights toward the tribes. Couched in the fiscal year 1984 budget, the President's policy on native Americans and recent administrative changes in Indian Health Service regulations is the sour scent of termination. Because of the facade the United States hides behind in terms of human rights, it is necessary to take the subtle approach that is being taken to abrogate the trust responsibility and existing obligations. There are five issues that I would like to focus your attention on. Those are the GAO report, the opportunity to avoid construction at certain IHS hospitals, that was done by the Government Accounting Office.

We have done an evaluation in response to that report which will be available, possibly, later on this afternoon. I can get a copy of that for you to include in this testimony.

The evaluations that were done on the nine hospitals in the area, I believe, were done on strictly a basis to reduce funding. I do not believe they ever looked at it in terms of the services that they were presenting. They were not looking at alternatives to existing things. They were totally looked at as a fund-saving measure for the administration. I think the authenticity of that report is highly questionable.

Senator MELCHER. Yes. We agree with your major points. Until they can offer something as good or better, it better be better. You know, it is not going to buy a pig in the poke.

Mr. ARCHANBAULT. We have gone out into the community hospitals that they were referring to. For instance, their costs for daily inpatient care, they wrote were something like $208 a day. IHS costs were reported to be somewhere in the neighborhood of $320 a day. Those costs are completely erroneous. In fact, they should be turned around. This is just a sample of the inadequacy of the report itself.

Senator MELCHER. Well, I do not know how the report got started. And it is inadequate, because on a cost basis, they actually incur more costs.

Mr. ARCHANBAULT. That is right.

Senator MELCHER. I do not think we have to figure in the extra transportation to demonstrate that there would be more cost.

We know why they were looking at it. The Appropriations Committee asked that we look at it, but we do not know why it was stated that it was going to cost less, when indeed, from all appearances, it is going to cost more. We were called recently by the area office here and they agreed that it would cost more.

So, I am a little bit confused on what instigated this report recommending the reduction of costs by closing the facility at Fort Belknap.

Mr. ARCHANBAULT. The second issue that we would like to bring to your attention is the Contract Health Service task force report that Jim alluded to earlier. And that report, again, was, we feel, more of a detriment than anything else because of costs that were reflected in them; things that were recommended, for example, enrolling again in an Indian Health Service enrollment. We have three enrollments on our reservation right now, and we do not need another one, to take care of things that we feel are duplicated by it.

Senator MELCHER. For whatever purpose they wanted the enrollment, there is plenty of enrollment available to them, is there not?

Mr. ARCHANBAULT. That is right. They have every enrollment that we have. Why do they need another one? And, having Indians pay for services is probably the most ridiculuous thing I have heard. Who do they pay to write this stuff? I would like to get in on that.

Senator MELCHER. We would like to know, too. A few years ago the President appointed a commission to cut down on paperwork. We envisioned saving thousands upon thousands of trees. I do not think we have reached that happy day yet. There is still more paperwork arising than we can shake a stick at.

Mr. ARCHANBAULT. The other one, again, we talked about in the other testimony is the reauthorization of the act itself. We think that has to be in place.

Senator MELCHER. You have CHR people?

Mr. ARCHANBAULT. Yes, we have.

Senator MELCHER. How many?

Mr. ARCHANBAULT. We have 11 on our reservation.

Senator MELCHER. Are they adequate?

Mr. ARCHANBAULT. We do not feel they are, because right now we are utilizing our CHR's in three cases that I know of for direct patient care. That is the eyeglass program and the dental program.

Senator MELCHER. The what and the dental?

Mr. ARCHANBAULT. Dental and eyeglass program. And the dialysis. We had somebody that administers the treatment on the dialysis machine to kidney patients.

Senator MELCHER. You say kidney patients. Do you have more than one kidney patient?

Mr. ARCHANBAULT. Yes, we do.

Senator MELCHER. How many?

Mr. ARCHANBAULT. Right now we have two on the reservation. We had five at one time, and three of them passed on. There definitely is a need for the CHR's. We have testified to that in previous hearings in Washington and here in Billings.

Senator MELCHER. Given the policy of coming down on CHR's, and perhaps not just minimizing them, but making them irrelevant, do you think we have turned the tide on that?

Mr. ARCHANBAULT. I think so.

Senator MELCHER. Do you think it is essential to make an amendment to require CHR's part of the reauthorization of the act?

Mr. ARCHANBAULT. I think that would be a tremendous improvement in the delivery of health care for Indians, because they are involved in a lot of areas in health care delivery. They are always on the chopping block.

Senator MELCHER. Yes, I know. It seemed to me they ought to be the last one on the chopping block.

Mr. ARCHANBAULT. I think what we have to do, sir, is, we have to develop true documentation, or statistics, as to what they actually mean to the community. We have begun to do that.

Right now, Ada White, who was supposed to give this testimony is at a National CHR task force meeting in Albuquerque designing something that is going to make the program more accountable for——

Senator MELCHER. Well, it is my intention to add another title to the reauthorization of this act—this is for CHR—so that then when

it comes to the budgeting programing by the administration, that this is something they have to look at and get into their budget.

Because, I well know the attitude of Congress, both in the House and the Senate. It is that this is very necessary, and this really is—as Jim Kennedy pointed out on behalf of the Blackfeet—is a way of stretching out the dollars and to make them reach.

I especially feel it is extremely important, both for the very young—the infants and the children—and for the very old.

Mr. ARCHANBAULT. That is right. There are very little program dollars that actually get to the older population. Like Fort Belknap, I was listening to Jim's testimony and our comments regarding the elders, and, you know, they really have been somewhat excluded in this whole process, because we have historically taken care of our own older people. They would not go anywhere. The rest homes are a new concept for them, and those have been in existence for years.

We established a unit at Fort Belknap in 1978 where we did have five or six of the older people in one area. However, because of funding cuts and this kind of thing, we were not able to continue that. Those people now are placed off the reservation, and once they leave, we never see them. They just do not come back.

In Indian tradition the elders have always been a respected segment of our society. They were the respect itself. We have come away from that. We have pulled away from that kind of idea, I feel. We have to, somehow, begin looking at that as a part of the health care delivery, because it is a health problem.

Senator MELCHER. The older I get, the more interested I become.

Mr. ARCHANBAULT. I think we all do. I think probably the last thing that I would like to mention regarding this report is the budget system itself. In allocating dollars, we must look at increases somehow. Perhaps getting that money from the top down to the patient is the only way left.

I do not think we have done that yet. We have gone out to the grassroots and cut programs and come into the area offices and cut programs. Perhaps we have to go up to the top and cut and get those dollars down here so that we can get the services that we need on the reservation level.

Senator MELCHER. Thank you Donovan. We are going to have to move on. We will pursue with the IHS people the point you raised on behalf of the Montana Indian Health Board.

Mr. ARCHANBAULT. We would also like to have you do something about the continuation for the extension of the committee itself, Senator Melcher. We think that your committee is the only true vehicle available to us to voice our opinions in the government. The government of the people, for the people, by the people; you know, we are part of that process, and you are the only thing that we have available, that we know about, to get our points across.

Senator MELCHER. We have a Senate resolution that would continue the select committee and 33 cosponsors, and we are going to have a hearing before the Rules Committee of the Senate sometime this month. We would anticipate being extended or made permanent, but we cannot be sure. But we want to be considered very shortly by the Senate. We hope it will pass.

Mr. ARCHANBAULT. Thank you, sir.
Senator MELCHER. Thank you.
[The prepared statement follows:]

PREPARED STATEMENT OF THE FORT BELKNAP COMMUNITY COUNCIL, PRESENTED BY DONOVAN ARCHANBAULT

The United States has an Impressive History for taking the side of the underdog on issues specific to Human Rights, Dignity and Prosperity. It's intervention in the name of Equality for the down-trodden nations of the world has fostered a vocabulary that has added a few pages to Old Webster. Alturistic, humanistic, humanism are but a few of these words.

The utter disdain that the Administration has toward the first people of this country show the true color and meaning of the rhetoric that so readily flows in it's denounciation of rulers of nations that abuse their people. At no time in History has a proud race of people been so brutalized, depreciated and maligned as the First Americans, for such a long period of time, by so many rulers. It would appear that the sanctimonious attitude of many of your colleagues and the many administrations that have ruled this country would diminish somewhat through the years, but that is not the case. Body's come and go, but the attitude remains; callowness, philistinism and negativism prevail; each pointing a finger at the next person, all blaming the Indian for "His" predicament. Not realizing or trying to understand why the situation exists.

Although much legislation has been enacted to negate the preconceptions that most people have of the American Indian, he still cannot leave the reservation and borrow money from the bank, receive equal consideration for employment, participate in other county, state and federally funded programs, for the most part, without experiencing all the prejudice and ridicule that exists in the American Society. The Indian is still experiencing the mentality exhibited toward the Japanese during and after the second World War. The Japanese in this country today are afforded far more social and economic privileges than the American Indian. The Indian wars have been over for one hundred years (100).

The Unemployment rate on the Fort Belknap Reservation has exceeded 70 percent since 1980, the mean rate for the past ten years has hovered at 50 percent, the mean income level for the reservation is currently $4,500.00 as compared to $15,000.00 nationally and $14,000.00 for the State of Montana. (Montana State Economic Development Office, U.S. Census). It would seem that the United States Government would bring about some parity in the distribution of resources and social equity within her own realm before venturing forth with a pointed finger.

Central to the Administration's Budget and it's blind betrayal of a trust responsibility which exists by virtue of signed contracts or treaties with Indian Tribes, is the need for adequate health delivery to Indians. This is not the case. The new budget exhibit's the true feeling of Human Rights toward the Tribes. Couched in the FY84 Budget, the Presidents Policy on Native Americans and recent Administrative changes in Indian Health Service Regulations is the sour scent of termination. Because of the facade the United States hide behind in terms of Human Rights, it is necessary to take the subtle approach that is being taken to abrogate the trust responsibility and existing obligations. There are five issues that I would like you to focus your attention on.

1. The GAO Report: Opportunity to Avoid Construction at Certain I.H.S. Hospitals, HRO 82–122:

The Report as it applies to the hospital at Harlem, Montana is incorrect for the most part. In order to put the whole issue in proper perspective, I must point out that the present condition and the serviceability of the Harlem Hospital did not get that way by itself. Instead, the deteriorated condition of the facility has been brought about by the bureaucratic mismanagement and political trade-offs. The Fort Belknap hospital was constructed in the late 1920's and early 30's, and it originally had been a thirty-three (33) bed hospital. Today we are looking at a facility that is over fifty years old and is now only an eighteen (18) bed hospital. Even though the hospital is accredited by the Joint Commission and Accreditation of Hospitals (JCAH) and the laboratory is accredited by the College of American Pathologist, many deficiencies still exist and services

continue to be reduced or cut. We have often questioned whether meeting JCAH requirements is wise if it continues to reduce the number of Health Services at the hospital. Obviously this is what Indian Health Service has allowed; they have terminated the service, rather than invest the time and money to upgrade the service to meet the JCAH requirement. As a result, we now have a first aide station, because we do not have an Intensive Care Unit, a cardiac care unit, modern or updated OB service, no surgical service, no diagnostic radiological testing, and the list goes on and on. To improve and catch up to the modern trends of medical care, some major efforts by Indian Health are necessary.

The authenticity of the contents of the report are questionable at best, i.e. the report lists two hospitals within fifty (50) miles of the Harlem Hospital. One of the hospitals is located in Malta, Montana, it is a non-accredited hospital. Fort Belknap is accredited; it has one physician. Fort Belknap has four (4); it has four services, Fort Belknap has nine services (9). The Fort Belknap Hospital will not utilize the Malta Hospital as a referral facility.

The other hospital is located in Havre, Montana and is a modern, fully staffed, accredited facility. The problem here, is the cost for available services. The costs for services reflected in the report (page 10) are erroneous. The cost at the community hospital is $350–450/day as opposed to $217.00 at the Indian Health Hospital.

To compare the costs of in-patient care at Northern Montana Hospital and the Fort Belknap Hospital would take an in-depth study. However, with the escalating health care costs it would probably cost between $7,666,500. to $877,000. for an increase of six daily patients in Havre, as compared to $400,900. to $450,000. at the Fort Belknap Hospital.

The most important concern of ours is the effect of closure of the Fort Belknap Hospital would have on the people, both financially and emotionally. One of our chronic health problems with the young children of American Indian descent is Otitis Media and upper respiratory infection, and occasionally the local physicians will admit the patient over night. Also, the older people have a real concern in going to hospitals away from this reservation. This point has been proven many times when a senior citizen has to be put in a rest home, usually these people live for a very short time after being placed.

It is my feeling that the report was not well researched, nor was the local Service Unit Staff's input used. Certainly, tribal input was conveniently circumvented and the Tribes at these facilities are for whom the service is intended. The report is a well disguised back door entrance toward termination, a method the current administration and congress are so strenuously employing through their Indian Policy.

The disfunctional state that all Indian Health Service Programs are in, here at Fort Belknap, are the result of the niggardly approach the administration has as the Indian Health Service relates to the budget. The bigotry of the administration should not be the burden of you, the lawmakers; instead, your decisions on the human need and the welfare of all the citizens of this country should reflect the Human Rights Doctrine espoused by the administration. If the Congress of the United States and this Administration are adamant in their strife towards human rights for all, then these bodies of the government must reconsider and increase the Indian Health Service budget for FY '84 in the areas addressed above.

In order to effectively address the health needs upon the Fort Belknap Indian Reservation it is imperative that the budget reflect:

(1) An adequate budget for realistic recruitment and retention of doctors for all Indian Health Facilities.
(2) The construction and maintenance of a modern facility with in-patient and out-patient capabilities.
(3) Adequate health services which are responsive to preventive health care and maintenance of Indian people.

2. Contract Health Service Task Force Report

Regarding the findings and the recommendations of the Special Task Force on the Contract Health Service, established by Dr. Rhoads, the Fort Belknap Community Council views this document as a second step toward termination of Indian Health Service obligations to the Indians of this country. The Task Force created in October 1982 to study Contract Health Services did not have ready

access to contract health care because of the great distances involved. At these (western) reservations, the Indian Health hospitals or clinics are considered primary by the Indian people rather than "residual" as viewed by the Indian Health Service. The Task Force individuals who are bureaucrats, interested not in the health and welfare of Indians, but in saving the government money at the expense of social programs. In actuality, the recommendations made by the Task Force are detrimental to the well being of Indian people.

The summary and recommendations of the Task Force emanates from the administrations political philosophy, in that congressional laws passed, are totally ignored.

For example, recommendations 3 and 4 are not parallel to the language in P.L. 94–437 Subpart A, 36.1 (a), (b). The law does not permit the Indian Health Service to force another enrollment of tribal members of services. Further, Subpart A, 36.12 (a), (b), and (c), clearly defines those individuals eligible for Indian Health Service, services.

Recommendations 5 and 6 are unrealistic. Perhaps the Task Force sits on the same level as the almighty and can determine what medical needs will be priorities over the next FY. It would seem that all health needs be taken on a case by case basis. Every medical needs should be a priority.

Recommendations 7, 8, and 9, pertaining to resource allocations should all begin with the words "Funding".

Recommendation (20) completely circumvents the law as states in Subpart C 36.25(c).

These are examples of the inappropriateness which permeates the report and its recommendations.

The Tribes here at Fort Belknap are appreciative that an attempt to alleviate problems in the C.H.S. area has been undertaken, however, are perturbed at the mentality displayed in the Task Forces recommendations. Although we do not have concrete solutions to all the problems that exist, I am sure that more realistic approaches can be explored.

3. Health Care Improvement Act:

This legislation should be continued for the simple fact that it *is* non-discriminatory and it provides a much needed service for Indians and non-Indians alike. It certainly provided the Doctors needed to deliver in-patient and outpatient care here at Fort Belknap. If tribes had to depend on I.H.S.'s feeble recruitment program, all of the I.H.S. Hospitals would have closed their doors decades ago.

4. The notion that Indians pay for direct services from I.H.S. is again a contradiction of the Snyder Act:

The legislation was passed with the intent to provide funds for health care delivery to Indians. In reality, a huge, cancerous, bureaucracy evolved and administration after administration perpetuates the problem. Laws are passed for mandatory salary increases for staff and services to the Indians are sacrificed. We, the Indians have to sit back and wonder where it all leads to.

5. High cost of health care over the past three years:

The budget increase over the last three years nowhere near reflects the inflated rates for health care. As stated earlier, the politics and mismanagement of resources prohibits a sensible direction in order to provide a viable health system for Indians and to fulfill the Government's obligations. Perhaps a pragmatic approach to the Dellima, is to utilize a fraction of the I.H.S. budget and purchase an insurance for the Indian. Regulations can be changed to accommodate this line of thinking, and eliminate the bureaucracy. This would save the Government approximately $720 million, and provide the Indians with a health service satisfactory to all.

The most reasonable change in Indian policy, would be to put the Indian back under the new War Department (defense). This agency seems to have a blank check to the Federal dollar.

This testimony is not intended to be unreasonable or facetious, it is in fact more reasonable and humanistic than the existing policy towards Indians. Why not think about cutting costs where it hurts less people and saves more dollars, lives, and limbs?

Thank you.

Fort Belknap Community Council

TRIBAL HEALTH DEPARTMENT

(406) 353-2205
P.O. Box 459
Fort Belknap Agency
Harlem, Montana 59526

Fort Belknap Indian Community
(Tribal Govt.)
Fort Belknap Indian Community
(Elected to administer the affairs of the community and to represent the Assiniboine and the Gros Ventre Tribes of the Fort Belknap Indian Reservation)

April 19, 1983
DATE

Everett R. Rhoades, M.D.
Director, Room 5A-55
Parklawn Building
5600 Fisher Land
Rockville, Maryland 20857

Dear Dr. Rhoades,

In response to the findings and the recommendations of the Special Task Force on the C.H.S., established by you, the Fort Belknap Community Council views this document as the initial step toward termination of Indian Health Service obligations to the Indians of this country. The Task Force created in October 1982 to study Contract Health Services did not have representation from the western part of the United States populated by Indians who do not have ready access to contract health care because of the great distances involved. At these (western) reservations, the Indian Health hospitals or clinics are considered primary by the Indian people rather than "residual" as viewed by the Indian Health Service. Not by any extension of one's imagination can Lionel R. John and Ross Swimmer be considered as "reservation" Indians. The remainder of the Task Force are individuals who are bureaucrats interested, not in the health and welfare of Indians, but in saving the government money at the expense of social programs. In actuality, the recommendations made by the Task Force are detriemental to the well being of Indian people.

The summary and recommendations of the Task Force emanates from the administrations political philosophy, in that congressional laws passed, are totally ignored.

For example, recommendations 3 and 4 are not parrallel to the language in P.L. 94-437 Subpart A, 36.1, (a), (b). The law does not permit the Indian Health Service to force another enrollment of tribal members for services. Further, Subpart A, 36.12, (a), (b), (c), clearly defines those individuals eligible for Indian Health Service services.

Recommendations 5 and 6 are unrealistic. Perhaps the Task Force sits on the same level as the almighty and can determine what medical needs will be priorities over the next F.Y. It would seem that all health needs be taken on a case by case basis. Every medical need should be a priority.

Recommendations, 7,8, and 9 pertaining to resource allocations should all began with the words, "funding".

Recommendation (20) completely circumvents the law as states in Subpart C 36.24 (c).

These are examples of the inappropiatness which permeates the report and its recommendations.

The Tribes here at Fort Belknap are appreciative that an attempt to alleviate problems in the C.H.S. area has been undertaken, however, are perturbed at the mentality displayed in the Task Forces recommendations. Although we do not have concrete solutions to all of the problems that exist, I am sure that more realistic approaches can be explored.

Because of the time element, we have responded only to the recommendations most deleterious to Indian Health Services. A more detailed opinion by our legal staff is forth coming. Thank you.

Sincerely,

Henry Brockie

Henry Brockie, Sr., Chairman
Fort Belknap Community Council

Fort Belknap Community Council

TRIBAL HEALTH DEPARTMENT

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P.O. Box 459
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Fort Belknap Indian Community
(Tribal Govt.)
Fort Belknap Indian Community
[illegible] to administer the affairs of the Community [illegible] to implement the Assiniboine and the Gros [illegible] Tribes of the Fort Belknap Indian [illegible]

June 6, 1983
DATE

MEMORANDUM

TO: Dr. Everett R. Rhoades, M.D.
FROM: Henry Brockie, Sr. Tribal Chairman
RE: Draft - Indian Self-Determination Memorandum (ISDM) No. 83-1
DATE: June 6, 1983

The draft copy of the Indian Self-Determination Memorandum No. 83-1 speaks directly to the administrative application of Public Law 93-638. The draft memorandum attempts to clarify various provisions of Public Law 93-638 which involves grants and contracts, tribal management funds, limitations on contracting, liminations on contracting tribal health advisory boards and liminations on contracting architect and engineering services involving construction of health facilities.

The memorandum appears to totally ignore the Indian Health Improvement Act which also speaks to grants and contracts of Indian Health care by Tribal Organizations and governments.

DISCUSSION

1. PL 93-638 Grants - Section 104 (b): Memorandum No. 83-1, page 2, outlines the Indian Health Service's definition of section 104(b) with respect to grants to tribal organizations. It states that, "the secretary is authorized, But not required, to make grants for the purposes described." This appears to be an intentional interpretation of the specific intent of this section. The specific intent of this section. The specific language states: "the Secretary of Health, Education and Welfare is directed, upon the request of any Indian tribe, to enter into a contract or contracts with any tribal organization of any such Indian tribe to carry out any or all of its functions, authorities, and responsibilities under the Act of August 5, 1954, (68 Stat. 674), as amended (42 USC §§2001 et sequ.)....., 25 USC §450g (a). Although there are certain limitations contained in that section relative to making grants to Indian tribes for Indian health care services, it can hardly be said that the secretary is not required because the language of the statute specifically directs the secretary to enter into contracts providing that certain requirements are met or maintained.

   Morever, Memorandum 83-1 ignores the specific language contained in the Indian Health Improvement Act, 25 USC Section 1601 et seq. 25 USC Section 1622 provides: "the secretary, acting through the service, shall make grants to or enter into contracts with tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian Reservations and trust areas...." The language contained in 25 USC Section 1622 is more of a mandate requiring

the Secretary of Health and Human Services to enter into and provide grants to Indian Tribal Governments for the purposes of carrying out the intent of the statute. (i.e. Indian Health Services).

Furthermore, Section 104(b) clearly intends that Public Law 93-638 contracts would include facilities. The Interior Department comments demonstrates this was the understanding. See House Report (Interior and Insular Affairs Committee (no. 93-1600, page 7794, December 16, 1974). The House Report, at page 7782, clearly contemplated the respective secretaries would enter into contracts as requested by the tribes unless good reason was present to decline. If such reasons were present, the secretary involved was to inform the tribe, and assist the Tribal Government or Tribal Contractor to correct the objections.

Clearly, it was the intent of Public Law 93-638 to make inapplicable, rigid federal procurement in contracting laws, to fulfill the primary purpose of the Act, i.e. to foster tribal Self-Determination and Self-Government. See House Report pp. 7781, 7782.

In reviewing Public Law 95-224, even if it were applicable to the relationships designated in Public Law 93-638, and it is unclear that it is, was not intended to change the substantive character of the federal relationship with any entity. See Senate Report no. 95-449, page 12, October 1, 1977. If intent was to make uniform the treatment of the various federal financial relationships. The Act allows for the individual agency to be flexible in circumstances which call for it. The Senate Report No. 95-449 pp. 19, 20. Certainly, the stated purpose of Public Law 93-638 would show that Congress intended tribal contracting agencies to be treated differently than the typical federal contractor.

Upon examining the legislative history of Public Law 93-638, with request to its intended purposes, it was not intended and it is not logical that the Indian Health Service has the authority on its own to subrogate the purposes of Public Law 93-638. Congress intended that some facilities would be needed for purposes of the Act to be accomplished. See Section 104(a), (b). The Interior Department made specific requests upon review of the Act that changes be made to give Section 104 the broadest possible interpretation. This recommendation included facilities. See House Report pages 7786, 7787.

Therefore, it appears that the secretary in Memorandum No. 83-1 is attempting to circumvent and subrogate the intent and purposes of Public Law 93-638 and as a consequence Indian tribes should be consulted more closely relative to the Indian Self-Determination Memorandum No. 83-1 becoming a formal policy of the Indian Health Service. It is clear in the law that the unique relationship which exists between Indian tribes and the Federal Government that Indian Health Care is a trust obligation and any attempts to circumvent or subrogate such a trust of the Indian Health Service must be prevented.

cc: Jim Danielson, Area Director
Leah Exendine

Senator MELCHER. Ted Risingsun for the Northern Cheyenne Tribal Council will speak on behalf of David Means, and David Means is director of the Northern Cheyenne Tribal Health Department. Please proceed, Ted.

STATEMENT OF TED RISINGSUN OF THE NORTHERN CHEYENNE TRIBAL COUNCIL, NORTHERN CHEYENNE RESERVATION, ACCOMPANIED BY DAVID NEESE, DIRECTOR OF HEALTH CARE, NORTHERN CHEYENNE RESERVATION

Mr. RISINGSUN. My name is Ted Risingsun. I am a member of the Northern Cheyenne Tribal Council and the Northern Cheyenne Board of Health. I am testifying on behalf of the Northern Cheyenne Tribe. I would like to thank the Senator and the Senate Select Committee on Indian Affairs for this opportunitiy to testify today. I have presented written testimony, and at this time I would like to summarize this testimony.

First, the Northern Cheyenne Tribe fully supports reauthorization of Public Law 94–437, Indian Health Care Improvement Act. We would like to recommend that the INMED program in North Dakota, receive continued funding in fiscal year 1984. We have one member of the tribe who has received an undergraduate degree through the INMED program. His name is Tim Wilson. He has been accepted to the Stanford University Medical School in California.

Continued funding of Public Law 94–347 may result in the Northern Cheyenne Tribe having one of its members as a primary provider of Indian health on the Northern Cheyenne Reservation. It is our understanding that some of the scholarships through this law are being awarded to Indian Health Service staff and families. We question whether or not this is an intent of the law.

We would also like to recommend that emergency medical service programs be included in Public Law 94–437 as a line item hopefully insuring continued existence of this vital program.

The Northern Cheyenne Tribe strongly requests the community health representative program be fully funded in fiscal year 1984.

We urge the committee to support increased funding levels for alcoholism programs throughout the Nation because it is recognized as the number one disease.

We would like to request that the committee support the national organizations, the National Tribal Chairmen's Association, the National Congress of American Indians, and the National Indian Health Board recommendations to fund emergency medical services at a level of $10 million for fiscal year 1984 and fiscal year 1985.

We would also like to request support to procure two new emergency ambulance vehicles. We have had 30 instances in the past two calendar years where ambulances broke down while transporting patients. Even as late as yesterday, July 7, 1983, an ambulance transporting a patient to the Crow Hospital broke down 19 miles from Crow Agency and required another unit to transport the patient back to Crow. And, I might add that the temperature was 100 degrees. The potential for further aggravation of injuries and/or loss of life is a strong possibility unless new ambulances are procured.

The Northern Cheyenne Tribe supports the elevation of the position of director of Indian Health Service to the level of an assistant secretary within the Department of Health and Human Services. We feel by such action Indian Health Service will have more leverage to present the health concerns and issues of tribes.

As an example, it is our understanding that even now Indian Health Service has been ordered by higher authorities to have a billing system in place by October 1, and to begin implementing recommendations on eligibility of Indians for health services.

It is our recommendation that Indian Health Service not take any action on these issues until they have shown how they are going to do it.

Indian Health Service is caught in a catch-22 situation where they are required to obey the mandates of the administration and still adhere to the intent of Congress. We feel that with Indian Health Service at an Assistant Secretary's level within the Department, they could better negotiate these contradictory situations.

We would also like to recommend that if the director of Indian Health Service is elevated to an Assistant Secretary's level, the Assistant Secretary's office remain accessible to Indian leaders or their health representatives.

The Northern Cheyenne Tribe would like to see increased funding levels for contract health services which is outlined in our written testimony, and see increased funding levels for pharmacy, dental programs, community health nursing programs, and for deferred surgery cases.

Thank you for allowing me to testify on behalf of the Northern Cheyenne Tribe.

Senator MELCHER. Ted, you summarized that statement very well. But we are glad that you gave us a statement in as much detail as you have. It is excellent testimony. You have covered some of the major points in which we have a great interest.

Even this point about whether the IHS director ought to be an assistant secretary or not is a very valid point now, because if it is going to happen, it is going to happen as an amendment to some piece of legislation. And this may be the proper vehicle.

Counsel here was just reminding me that Emery Johnson, the former director, while he was the director, spent up to 85 percent of his time talking to his superiors. They really knew nothing about what he was talking about to begin with, but he had to talk to them, because he was not an assistant secretary.

Now, we get around that. Maybe we will see a little more action out of Washington from the top guy and less time having the director explaining to other people in HHS what Indian Health Service is all about.

So we may make a real effort this time in these amendments to include that; to make the director of IHS assistant secretary so he does not have to talk to so many people at the various bureaucratic levels. He can go directly from his office right to the director or the secretary of HHS. I would just like to see a little more efficiency, particularly on the Washington end.

They cannot berate IHS for not having the director at that level. I think to straighten it out, Congress should intercede and put into

the law a requirement that that office carry with it, not only a diector in IHS, but an assistant secretary. So we remove a rather big layer of bureaucracy that the director has to go through before he can do anything to get approval for these programs.

I want to ask you some standard questions. First of all, are you using CHR's?

Mr. RISINGSUN. Yes.

Senator MELCHER. How many?

Mr. RISINGSUN. We have 13.

Senator MELCHER. Do you think 13 is adequate?

Mr. RISINGSUN. No; it is not adequate, knowing the reservation as I do.

Senator MELCHER. Do you have any money owed to you by the Montana Indian Health Board?

Mr. NEESE. My name is David Neese. I will respond to that.

Senator MELCHER. All right.

Mr. NEESE. We have had some money owed to us for travel, nonpayment of travel for the representatives from the Northern Cheyenne. And that is about it.

Senator MELCHER. Do you know how much?

Mr. NEESE. Right now about $3,000.

Senator MELCHER. How long has that been pending?

Mr. NEESE. I came on in 1980. It was prior to that.

Senator MELCHER. Has there been improvement in the area office since the appointment of the new director?

Mr. NEESE. I think there has. We have not had that much communication at this point, but there seems to be a better morale, and people seem to me to be more open to listen and assist. That is my personal feeling, and it also reflects that of the service.

Senator MELCHER. David is the director of health care at the Northern Cheyenne Reservation.

David, have you been there since 1980?

Mr. NEESE. Yes.

Senator MELCHER. Where were you before that?

Mr. NEESE. I was with Indian Health Service.

Senator MELCHER. You were with the Indian Health Service, located here? Were you stationed here in Billings?

Mr. NEESE. No; I was stationed in a Northern Cheyenne Service Unit.

Senator MELCHER. The alcoholism rehabilitation program on the Northern Cheyenne has had the attention of Ted Risingsun and a lot of other people. How is that progressing?

Mr. NEESE. We feel that the funding levels that we receive, and I think through the area receive, is not adequate to really develop a comprehensive program. At this point the funding levels we receive from Indian Health Service, through a contract, is funding basically the detox program.

Fortunately, the tribe has assisted the alcohol program by appropriating some money to begin a halfway house. We still have to refer most of the clients for treatment to other places.

Senator MELCHER. Where is the halfway house?

Mr. NEESE. It is located in Lame Deer. But that is through tribal funding. We do not know if that is going to continue or not.

Senator MELCHER. Ted, how many ambulances do you have operating as of today?

Mr. RISINGSUN. Five; two are tribal.

Senator MELCHER. Are they all operating today?

Mr. REESE. No.

Senator MELCHER. How many are operating today?

Mr. NEESE. Well, there is one, like Ted mentioned, which broke down yesterday. We are not sure what the problem with that one is. The two tribal ones are not really ambulances in the sense of an ambulance vehicle. One is a converted van; and the other two IHS vehicles have problems. One does not start. After it starts, you cannot turn it off because it will not start again.

Senator MELCHER. There is a mechanical failure?

Mr. NEESE. Mechanical or electrical failure. They have had several instances where they have been transporting patients to the hospitals at night and the lights go out.

There is a problem with the steering in the other van. It tends to, as people tell me, to go all over the road. It scares them.

Senator MELCHER. The three might be enough if they were all operating, but you have not been able to secure repair through IHS?

Mr. NEESE. They have a lease through the GSA motor pool, and they are sent there continuously. But the problems persist.

Senator MELCHER. You mean they sent somebody from the motor pool?

Mr. NEES Yes; there is a motor pool mechanic who comes down from Crow to Lame Deer. He checks them out. Then he refers them up to here. There is a motor pool up here in Billings, a GSA motor pool. They repair them, check them out. But they come back, we still have continuous problems with them.

Senator MELCHER. That is about a hundred mile trip up here?

Mr. NEESE. Right. And anytime we send an ambulance from Lame Deer, it may take from 3 days to a month that that ambulance is out.

Senator MELCHER. Isn't there anyone in Lame Deer who repairs these vehicles?

Mr. NEESE. Not these kind of vehicles, I guess. Because, I guess they are pretty complex in their electrical system.

I might mention that when we got the first ambulance in 1979, the alternator burned out the day we got it.

Senator MELCHER. Who makes these?

Mr. NEESE. It was a company out of Texas. They made an agreement with a company out of Texas. I am not sure of the name. From what I understand, they are no longer in business. I may be wrong on that.

Senator MELCHER. We are going to try to straighten that out. You have written to us about that, and we are interested in pursuing it. Hopefully, IHS can fill us in on that today.

Thank you both very much.

Mr. RISINGSUN. We thank you.

[The prepared statement follows. Testimony resumes on p. 103.]

PREPARED STATEMENT OF THE NORTHERN CHEYENNE TRIBAL COUNCIL, SUBMITTED BY TED RISINGSUN, MEMBER

I would like to thank the Honorable Senator Melcher for allowing the Northern Cheyenne Tribe to testify before this committee.

We would like to present to you some important issues and concerns of the Northern Cheyenne Tribe about the health delivery systems on the Northern Cheyenne Reservation.

I. REAUTHORIZATION OF PUBLIC LAW 94–437

The Northern Cheyenne Tribe concurs with the rest of the tribes in the nation and with the national organizations in supporting the reauthorization of Public Law 94–437, the Indian Health Care Improvement Act, with the following recommendations.

TITLE I—INDIAN HEALTH MANPOWER

The Northern Cheyenne Tribe strongly urges that continued support be made for the INMED Program in North Dakota. We have a personal stake in this program, as one of our Tribal members has completed an undergraduate degree in Science, and has been accepted to Stanford University in California to continue his education as a medical doctor. This has been done through the authorities of Public Law 94–437.

For the record, we would like to mention his name, Mr. Tim Wilson, who was an outstanding student at the University of North Dakota, INMED Program, and was recruited by University of Washington, University of North Dakota, and Stanford University with a couple of others to attend their medical schools. Mr. Wilson has decided to go to Stanford University in California to continue his education in the field of Medicine. He has, also, been accepted to the National Institute of Health in Hamilton, MT for a summer job. It is our understanding that presently INMED is administering 62 scholarships for Indian people in the medical field. It is our hope, that if INMED is continued, we will see the results by having a member of the Northern Cheyenne Tribe as one of the primary providers of Health care on the Northern Cheyenne Reservation.

We recommend that INMED be retained as a line item within Public Law 94–437, Title I, in order to continue to allow Indian people the opportunity to further their education in Medicine.

Title II—Health service

The Northern Cheyenne Tribe recommends that funding levels be increased to fulfill the goal to eliminate back logs in the Indian Health Care Services.

Title III—Health facilities

We, again, request funding be improved to continue construction of Indian Health Service facilities, hospitals, health centers, health stations, and to improve and construct safe water and sanitary waste disposal facilities.

The Northern Cheyenne Tribe has had a dream that one day we will be able to see a hospital here on the Northern Cheyenne Reservation. We will continue to seek that dream, and through this Title III, we may be able to obtain a hospital in the future.

Title IV—Access to health service

The Northern Cheyenne Tribe recommends that Medicare and Medicaid reimbursements for services preferrably be retained here at the local service unit, and if not there, at the area offices.

Title V—Health services for urban Indians

We recommend that Urban Indian Programs not be phased out of Indian Health Services budget, because it is our contention that if services are eliminated in urban areas many of the Indian people will return to the reservations [illegible] greater demand on the limited health resources that are available on [illegible]ons.

II. COMMUNITY HEALTH REPRESENTATIVE PROGRAM

The Northern Cheyenne Tribe concurs with National Indian Health Board, the National Congress American Indians, and National Tribal Chairman's Association, and the National Counsel Clinical Directors in their support of the

CHR Program. The Northern Cheyenne Tribe would like to extend their appreciation to the Congress for their restoring the CHR Program for fiscal year 1983, and would like to ask this committee to recommend again to the Congress to continue funding the CHR Program.

Our request concurs with the request of National CHR Associations 36.3 million dollar request for fiscal year 1984. If this can not be achieved, we would like to recommend that 29 million dollars be put back into the fiscal year 1984 for the CHR Program.

If the CHR Program is not funded, we feel that the cost, both human and financial, will increase and will be counter-productive to the intent of the Congress in trying to reduce National Deficit.

I must refer to the statistics that I am sure you are most familiar with that shows the worth of the program, since fiscal year 1969, when there was an increase of out-patient visits, direct patient admissions, and increase of hospital days. It is our belief, that by having a CHR Program that is working with the patient in a rural setting providing home health care, interpreting for the non-English speaking patient, providing transportation for those that do not have rides to the medical facilities, providing emergency medical services, providing assistance to Indian Health Service and the eye clinics, dental programs, kidney dialysis, ear, nose, and throat programs, Well-child clinics, Diabetic clinics, providing assistance to the elderly, providing health education, the financial and human costs for Indian Health Service and the Northern Cheyenne Tribe will be contained.

Again, we ask this committee to strongly urge the Congress to support the continued funding of the CHR Program for the fiscal year 1984, and future fiscal years.

Additionally, we suggest that Indian Health Service shift CHR budget line item from Preventive Health category to Clinical services category, and that line item status be maintained.

III. NORTHERN CHEYENNE ALCOHOLISM PROGRAM

The Northern Cheyenne People were once a proud nation, excellent hunters, and feared in battle, but today, the Northern Cheyennes are fighting another battle and maybe losing it; that is the battle against alcoholism.

All people living on the Northern Cheyenne Reservation today are affected by Alcoholism either their own or that of a relative, and the problem is still growing, especially among our youth. The future leaders of the Cheyenne Nation are being raised in the chaos of the alcoholic family, and in turn they themselves start to use alcohol and drugs in an attempt to deal with the stress and depression of their lives.

Today, we see more Indian people in jails, prison, hospitals, and mental institutions as a result of alcohol and chemical abuse than ever before, and we have lost many members of our tribe before the age of 50 years with deaths due to our Number One problem. For a culture, which reveres its elders and looks to them for leadership and guidance, this is a serious breakdown of the way of life resulting in spiritual confusion.

The sharing and helping of the extended family is gradually being replaced by apathy, after the manipulations and dishonesty of this disease has taken advantage of each family member in order to support one thing; obtaining enough goods or money to trade for enough to drink; in order to get through just one more day without getting sick. Marriages have been ruined, children neglected and abused, and lives lost as well as respect for ourselves and others. Indian alcoholism affects the culture as a whole because it has lead to the stereotype, "They're all like that."

Alcoholism is a nationwide problem, ranked third as a killer behind Cancer, and Heart diseases: We believe that figures do not truly reflect the enormity of the problem. For instance, they do not reflect deaths on the highway, shootings, stabbings, drownings, hypothermia, burns, asphyxiation, and suicide due to alcoholism.

Often the immediate cause of death is noted on the death certificate, but never the underlying disease—Alcoholism or Chemical Dependency. We believe that if all of these statistics were complied, Alcoholism and Chemical Dependency would be ranked nationwide as our nation's number one killer.

Alcoholism affects the whole area in which we live, not just our reservation. For instance, in Big Horn County (adjacent to the Northern Cheyenne Reserva-

tion) between January 1981 to December 1982, there were 72 Northern Cheyenne people arrested for alcohol-related offenses. Also, there are thousands of dollars owing to merchants in the surrounding area in unpaid credit dollars, because alcoholism destroyed the financial base of many families.

Another problem which compounds the difficulties in dealing with alcoholism is the high rate of unemployment on our reservation. The last estimate was that 40 percent of Northern Cheyenne people were employed. We spend time and money in rehabilitation for our alcoholics [1] and then when they are sober, we cannot offer them work and the self-respect and quality of life produced by employment.

We believe that a giant leap forward could take place if funding was available to relieve the alcoholism and unemployment simultaneously.

Currently, no funding is received from the State of Montana for alcoholism prevention, education or treatment, either through state block grants or local impact funds.

The Northern Cheyenne Reservation is impacted as much or even more than most Montana communities by coal development. The area to the north of the reservation is under current development, for example, Colstrip has brought with it social problems, most of which appear to be related to an increase in the abuse of alcohol and drugs. Unlike Colstrip, the reservation has not garnered the social benefits of development, such as, good housing, business expansion, more facilities, etc. We have been negatively affected, yet, do not receive any impact assistance. There appears to be a large increase in the illegal drug trafficking on the reservation since the expansion at Colstrip, and admissions to Detox have reflected on this. Most admissions have been involved with at least one other drug besides alcohol, particularly those admitted under the age of 35.

In 1972, the Northern Cheyenne Tribe received a $59,512.00 NIAA grant to provide alcoholism counseling services within the tribal area. The NIAA Program completed transfer to Indian Health Service on December 1, 1978. In 1974, IHS provided a detoxification contract of $53,000.00 per annum. In joint, Tribal/IHS planning effort, the grant and contract were combined in one contract, this had the advantage of providing enough personnel to staff the Crisis Unit 24 hours a day, 7 days a week and provide some counseling services.

Also, our current level of funding under this contract is $112,000.00.

The Northern Cheyenne Tribe provide a building located next to the IHS Clinic which will allow space for 10 clients to detoxify.

Also, a short term (1 year) grant for the Northern Cheyenne Tribe is providing 3 outreach workers, 2 cooks, a Data co-ordinator, and 2 Halfway House personnel.

The ground work has been laid for a permanent Halfway House component and outreach workers to work with disrupted families, however, we have no guarantee that the Northern Cheyenne Tribe will be able to provide this after September, 1983. The reason for this being not lack of commitment by the Northern Cheyenne Tribe, but lack of financial resources.

The population of the Northern Cheyenne Tribe is approximately 5,000, and the reservation covers 444,000 acres. There is no public transportation and many families live in rural surroundings and cannot reach services available, so it is crucial that the Outreach and Halfway House component continue after September, 1983.

The current IHS budget barely scratches the surface of the problem providing services only after a person has full blown alcoholic symptoms, it does not provide for prevention, education, treatment or aftercare for early stage alcoholics who are willing to deal with their problem—NCAP current services under the IHS are for detoxification and referral to treatment only.

Under the current grant, there is no continuity of care, so no aftercare can be provide for those returning from treatment.

In fiscal year 1980–81, there were 301 admissions to Detox, in fiscal year 1981–82, there were 239 admissions, from October through June of this year, there have been 215 admissions.

The reasons that the number of admissions to detox dropped in those years was because we had no permanent facility. The program was housed in a condemned building and it moved six times in four years. In some of these buildings, there was not enough bed space and people who were sick had to be turned away.

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[1] 1982, BIA Labor Force Report Northern Cheyenne Agency.

Early in this year, the Northern Cheyenne Tribe built a new facility next to the IHS Clinic which is permanent.

Community awareness of the problem has never been better. In early 1983, the Northern Cheyenne Youth Task Force was formed by concerned parents and community members. The objective of the Task Force is to provide Intervention, Treatment, and Aftercare for Youth in trouble with alcohol and drugs. In the first six months, since the Task Force was formed, seven teenagers have been referred for treatment of their problem, and available funds are now exhausted. So while community interest is high, financial support is low and this program cannot function effectively. In the next few years our financial needs are thousands of dollars ahead of the actual budget.

Our major needs can be outlined as follows:

1. A treatment center for a 28-day primary residential treatment of alcoholism and chemical dependency located here on the Northern Cheyenne Reservation with a unit for treatment of family members. The problem is here, the people are here, the resources for help are here, but cannot be developed at current funding levels; for those with no finances for treatment we utilize the following treatment programs currently:

(a) *Inter-tribal Alcoholism Treatment Center—Sheridan, Wyoming.*—Funded by IHS, this center is 80 miles away in the state of Wyoming and has only 15 beds provided for four reservations. There is no way that 3½ beds/monthly can meet treatment needs for this reservation. We, wholeheartedly, support further expansion of this center.

(b) *Drug Dependency Unit—Winnebago, Nebraska.*—This is a 13 bed treatment center provided by IHS for service to Omaha, and Winnebago Tribes and reservations in North and South Dakota. We are able to refer 1–2 clients/monthly to this center as bed space is available. However, this involves a 1200 mile trip by bus for our clients and while providing a good treatment experience is divorced from the reality of life in the Northern Cheyenne community.

(c) *Galen State Hospital—Deer Lodge, MT.*—This is financed by the State of Montana. This treatment center provides a good basic treatment for alcoholism, however, the demand for services at this center is so great that, we have difficulty in obtaining dates for entry into this program without a lengthy waiting period. During this time, it is difficult for the client to hold their sobriety and they often relapse into drinking and lose interest in the treatment process.

As noted, these treatment centers are all located away from the Northern Cheyenne Reservation and problems arise separating clients from their families, especially women with children.

With a treatment center located on our reservation, we could treat the total family in a healthy and realistic environment and research has shown statistically that when a family member enters into the treatment process there is a higher success rate for sobriety.

Because of the stress caused by living with an alcoholic in the family, spouse and children are often as sick if not sicker than the drinker/abuser. Inappropriate handling of this stress often gives rise to nervous breakdowns, severe depressions, neglect of self and children. The fact remains that the rest of the family need not suffer if treated, and since they are not often involved with alcohol and illicit drugs themselves, are eminently more treatable than the alcoholic. If this sector of the Northern Cheyenne Tribe receives help it could mean a tremendous financial savings to the community for hours of work lost, health care, loss of school time, juvenile delinquency, etc.

As part of treatment, a family member learns ways of avoiding senseless arguments with the alcoholic, so accordingly there should be a drop in police calls on spouse battering, and domestic violence. A family unit could have widespread impact on the community for the amount of dollars spent.

We also need funding for prevention and intervention. This is one of the most effective programs for the amount of money spent.

Prevention programs and techniques are already developed that can be highly effective in combating alcohol and drug problems before they start or in the early stages.

However, finances are needed to train our school personnel and parents to administer these programs. Children who develop a positive image of themselves and who can communicate well and who have learned problem solving skills are less likely to become addicted late in life, but they need help from parents and teachers to develop these.

In the short time that children have been educated about addiction to alcohol and drugs in our schools, we have seen positive results. Even with these minimally funded efforts, people are seeking help at a younger age before their problem is out of hand. In the past two years, the average age of admission to the Northern Cheyenne Alcoholism Program dropped from 35–45 years to 25–35 years of age, and in the first six months of this year juvenile referrals increased by 300 percent. With the growing awareness of the symptoms of alcoholism, people are recognizing the symptoms in the early stages.

Funding to develop Employee Assistance Programs on our reservation would be dollars well spent. An Employee Assistance Counselor can often intervene while the alcoholic is still employed, thus saving much money in lost working hours, sick pay, and low job performance. The alcoholic has more motivation to seek treatment if his job is being jeopardized by an employer who often has more "clout" in the situation, than the family members.

Another situation that is a serious problem to us is Fetal Alcohol Syndrome.

When a woman is pregnant and drinks even a small amount, she may risk having a baby that is affected by Fetal Alcohol Syndrome. The symptoms of this condition range in severity from facial abnormalities to severe retardation. In the past year alone, seven children with Fetal Alocohol Syndrome were born to Northern Cheyenne mothers and many more will be diagnosed when they enter Headstart and Kindergarten.

This is very sad because Fetal Alcohol Syndrome is totally preventable. We desperately need funding for the education of families and young women on the effects of drinking and pregnancy.

The long term effects of a lowered I.Q. and impaired motor coordination or the future generations of the Northern Cheyenne people is difficult to estimate, but as widespread as the current problem is, it will have a devasting effect and problems 20 years from now may make our current ones seem minimal in contrast to the effect of Fetal Alcohol Syndrome.

As mentioned before, we believe that Halfway care is important follow-up for many of our people after they leave treatment centers. Some have no homes, others live in rural areas with no access to services. The groundwork for this is in a place, but we desperately need financial support to keep it going. We, also, see the need for a separate Halfway House for women where they can have their children. Many mothers do not enter treatment because of fears that the Welfare Agency will remove the children from the family while they are away.

We see a great need for continuation of support for the whole family unit while recovery is taking effect.

Also in the future, we may need a larger detoxification unit with 30 beds in order to cope with those that are sick and needing a referral to treatment.

The Northern Cheyenne Tribe urges this committee to recommend increased funding for Alcoholism Programs and also, request that the No. 1 problem be made a budget line item.

IV. EMERGENCY MEDICAL SERVICES

The Northern Cheyenne Tribe would like the committee to look into two major issues concerning Emergency Medical Services on the Northern Cheyenne Reservation.

A. The Northern Cheyenne Ambulance Service has been funded by the Northern Cheyenne Tribe since Januaray 31, 1980. Several contract proposals have been submitted to Billings Areas IHS under the authorities of Public Law 93–638, but none have been funded. The only funding for EMS that the Northern Cheyenne Board of Health receives is three positions within the CHR budget. With continued cutbacks of federal dollars on the reservation level, the tribe has been forced to use their resources to fund vital programs such as, the Northern Cheyenne Ambulance Service, thus draining an already over burdened tribal funding source. It has been projected that tribal funds will be less in fiscal year 1984–85 forcing drastic cutbcaks in health related programs. It is the tribe's contention that the resposibilities for Emergency Medical Services for Northern Cheyenne Tribe lies with Indian Health Service.

Therefore, in order to continue the present level of Emergency Medical Services, we would like to recommend that this committee strongly urge the Congress of the United States to take the recommendations of National Indian Organizations and approve a 10 million dollar budget for Emergency Medical Services in fiscal years 1984–85.

B. The Northern Cheyenne Tribe has an immediate concern that was presented to you, Mr. Melcher, in a letter dated June 8, 1983 from Mr. Allen Rowland, President, Northern Cheyenne Tribal Council, that asked for your support in securing two new operational fully-equipped ambulance vehicles. As outlined in the letter, there have been at least 30 incidences when ambulances broke down during patient transport during the past two calendar years.

We have requested your assistance to procure two ambulances because on January 5, 1982, a memorandum was sent out from the Office of Research and Development advising all IHS Area EMS Coordinators that due to funding limitations, prospects for funding becoming available in fiscal year 1982 for ambulance replacements appear slim at best. We had not received any information on ambulance replacements for fiscal year 1983 until the week of June 27th, when the Ambulance Service Director attended an EMS Managers Conference in Rapid City, South Dakota.

At this time, he was advised that IHS would be procuring nine ambulances in fiscal year 1983 and 22 ambulances in fiscal year 1984. He was also, advised that the nine ambulances in fiscal year 1983 have already been placed.

It is our concern that we had not received any information in ambulance replacements from IHS, if we had we would have attempted to try to get at least one of the ambulances. In talking with the Ambulance Service staff it is their belief that the present vehicles may not last until fiscal year 1984. Therefore we wish to request your support in procuring two ambulance vehicles and also wish to urge this committee to support additional funds for ambulance vehicles above the projected for fiscal year 1984 above and beyond the already projected 22 vehicles.

V. INDIAN HEALTH SERVICE—DEPARTMENT LEVEL

The Northern Cheyenne Tribe supports the concept of elevating the position of the Director of Indian Health Service to the level of an Assistant Secretary within the Department of Health and Human Services. The reasons why the Northern Cheyenne Tribe supports this concept is as follows:

1. With Indian Health Service being at Department level, much of the red tape will be eliminated because Indian Health Service will not have to go through HRSA and PHS to get their concerns heard.

2. It is our understanding that when funds are appropriated for Indian Health Service, HRSA receives part of the allocation to fund positions to oversee Indian Health Service. With Indian Health Service being at the Department level, money may be saved by eliminating the positions in HRSA and hopefully those savings could be utilized at the local Service Unit level.

3. When funding cuts came down in fiscal year 1981, many of the tribes recommended that cuts be taken at the headquarters and area levels that Reduction in Force be implemented. Tribes were advised that Reduction in Force could not be implemented except through the authority of Department of Health and Human Services. It may be easier in ensuing years to get Reduction in Force implemented if IHS were at Department level.

VI. RESPONSE TO INDIAN HEALTH SERVICE TASK FORCE REPORT ON CONTRACT HEALTH SERVICES

On April 28, 1983, the Northern Cheyenne Board of Health reviewed the task force report at a regular meeting. Attached is a letter dated May 5, 1983 to Dr. Everette Rhoades, Director, Indian Health Service outlining their concerns on the proposed recommendations of the task force.

VII. IMPACTS ON NORTHERN CHEYENNE SERVICE UNIT HEALTH CENTER

The Northern Cheyenne Tribe has the following concerns of Service Unit services provided by IHS-Northern Cheyenne Service Unit.:

(a) Contract Health Services: The Contract Health Service program is a program that has always been underfunded. This program provides care beyond the scope for local service unit. Currently, the only life saving cases are being referred out, so cases such as those that need diagnostic services to determine the causes of chest pain are not being referred out because they are not life threatening situations. The physicians are faced with the thought that the next symptoms they see may be sudden death. This will lead to anguish and sorrow for the family and possible malpractice suit for the physician and may impact the

retention of IHS physicians in the future. We would like to urge the committee to concur with the House of Representatives' funding level at $165,427,000.00 for Contract Health Services.

(b) When Northern Cheyenne Service Unit received the mandate to cut funding levels, the pharmacy has not been able to sufficiently maintain adequate drug inventory levels. There is barely enough money for prescription only drugs and over the counter drugs have been eliminated. There are some over the counter drugs that are legitimate treatment for diseases, i.e., aspirin is used to treat rheumatoid arthritis, but due to the elimination of aspirin the pharmacist is required to give out motrin which is more expensive.

(c) Another problem that the Northern Cheyenne Service Unit has had to deal with is that it is an 8–5 outpatient clinic that provides 24-hour emergency services. Due to the isolation and distance from definitive care hospitals and if there was not a 24-hour emergency service, we feel that the morbidity and mortality would increase. In order to provide a 24-hour service, daytime staff are put on call during evening hours, night, and weekends. This causes daytime clinic to be shorthanded and staff be under considerable stress.

To assist in overcoming this problem and continue quality service we would like to urge this committee to support a request for at least two nursing positions.

(d) We would also like to recommend that the Northern Cheyenne Health Center receive $140,250 for deferred surgery cases. As you are aware, only emergency cases are referred out and these deferred surgery cases are put on a waiting list until they become acute or emergent. We feel that by waiting to take care of the non-emergent deferred surgery cases until they are acute will result in higher financial and human cost.

I would like to thank the Senate Select Committee on Indian Affairs for allowing me to testify on behalf of the Northern Cheyenne Tribe.

Northern Cheyenne Board of Health

P.O. BOX 8
LAME DEER, MONTANA 59043
(406) 477-6284

May 5, 1983

Dr. Everette R. Rhoades, Executive Director
Indian Health Service
Department of Health & Human Services
Health Resources & Services Administration
Rockville, Maryland 20850

Dear Dr. Rhoades:

The Northern Cheyenne Board of Health reviewed the Task Forces' report on CHS at a regular meeting on April 28, 1983.

The Board concurs with many of the concerns and problems pointed out by the Task Force and the proposed changes necessary to improve delivery of services to Indian People.

The Board would like to respond to several of the proposed recommendation as follows:

1. First of all, the Board is aware that a three year implementation plan has been completed and is being reviewed at this time. It is discouraging that the plan is being strongly looked at without input from tribes.

   We also feel that it may be better to respond to the implementation plan.

2. The Task Forces' recommendation on the Eligibility criteria is questioned by the Board of Health for the following reasons:

   If a newborn child is not immediately enrolled by a Tribe, would they still be eligible for services if they are not a member of a federally recognized tribe.

   Tribes do not alway enroll immediately and the Board of Health recommends that some clarification be made on this issue prior to adoption.

3. National priorities for clinical care is not acceptable to the Board of Health. The Board feels that each reservation has certain problems that are unique to their area. Prioritization should be set at the local service units.

4. The Board of Health also would like to express an opinion on the Task Force's recommendation on implementing a fiscal agent concept.

The rationale seems to be sound that a fiscal intermediary may cut down expenditures and tighten up the system.

The Board of Health does recognize, however, that replacing the present CHS system with a fiscal intermediary may eliminate another IHS function that the Tribes have the right to contract through P.L. 93-638. We would like to request additional information on how tribes would have input in the fiscal agent process, and if tribes are able to contract this function.

5. The Board of Health also recommends that any implementation of the Task Force's recommendation be publicized and all beneficiaries be informed through a thorough education program.

We must stress the Board of Health will reserve the right to respond with any additional comments and recommendations as changes come to our attention.

If you have any questions, feel free to call me at 477-6722/ 6775.

Sincerely,

David A. Means, Director
Northern Cheyenne Tribal Health Dept.

cc: Files
BOH
N.C. Tribal Chairman
Allen Rowland

Senator MELCHER. Norman Hollow, chairman of the Fort Peck Tribal Executive Board.

STATEMENT OF NORMAN HOLLOW, CHAIRMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK INDIAN RESERVATION, ACCOMPANIED BY DENNIS DOKER, JR., MEMBER OF THE TRIBAL EXECUTIVE BOARD

Mr. HOLLOW. Senator, my name is Norman Hollow. I am chairman of the Assiniboine and Sioux Tribes of the Fort Peck Reservation. I have with me Dennis Doker, Jr., who is a member of the tribal executive board, and also a member of the health, education and welfare committee. He is quite familiar with health matters, and that is my reason in having him accompany me down here today to take part in the presentation, and perhaps answer some of the questions that might be raised from time to time.

I am very happy to have the opportunity to express our views concerning health matters. Particularly with reference to the renewal of the Indian Health Care Improvement Act.

Initially, Congress passed the Indian Health Care Improvement Act in 1976, the health status of Indians was far below that of other Americans. And on the basis of this, I have a statement, and I would like to submit that for the record at this time, and I would like to summarize some of the highlights in my statement. I regret that Congress, if another survey is made, will find the same findings today that existed back in 1976. The fact that progress was made during the 1960's and 1970's has been completely halted since President Reagan severely cut the Indian Health Services' budget. The situation has deteriorated badly.

In my testimony today I will urge reauthorization of the Indian Health Care Improvement Act.

Contract care is provided at two community hospitals on the Fort Peck Reservation. One hospital in Poplar—one clinic in Poplar, and one in Wolf Point. The Indian Health Service at Fort Peck is responsible for the two clinics: one in Wolf Point and the other in Poplar.

The one in Wolf Point is very small and lacks X-ray and lab facilities. In fiscal year 1982 all patient visits to Indian health facilities numbered a little over 30,000 in Poplar and a little over 15,000 in Wolf Point, for a total of a little over 46,000 outpatient visits.

When these facilities are not equipped to handle a particular problem, the patient is treated at a facility off the reservation, usually in Billings, Williston or perhaps sometimes in Seattle.

There is a serious backlog of contract care cases on the reservation, but particularly surgical cases. As a result of this, the Assiniboine and Sioux Tribes strongly support reauthorization of the Indian Health Care Improvement Act.

The goals of the act were to promote better Indian health. If the act had been implemented as Congress had originally intended, reauthorization may not even be necessary. Unfortunately the appropriations have fallen short of the amounts authorized by the act.

This combined with the overall cuts in Indian Health Service budget which Congress has made at the request of President Reagan has

meant that many tribes have not been able to hold the line in the provision of Indian health services, much less improve such services as contemplated by the act.

I would like to comment a little on problems in relationship to contract care. At Fort Peck alone, we need over $300,000 in additional contract care funds just to eliminate our current backlog. As of last winter, we had 200 patients waiting for surgery, including those cases for cataracts, orthopedics and gall bladder problems.

We also need additional contract care funds for problems caused by alcohol, such as cirrhosis of the liver, and of course cases of diabetes.

At present the only patients who have access to contract care funds are those whose conditions have deteriorated to the point of an emergency. At this point medical care is much more expensive.

The House Appropriations Committee has recommended a $26.2 million increase in contract care funds for fiscal year 1984. In light of the nationwide crisis in contract care, we recommend that contract care be addressed separately in the reauthorized act, and that enough funds be authorized to eliminate the backlog within 2 years.

I would also like to comment on mental health services. We are simply unable to meet the demand for mental health services. The need for such services always increases during an economic recession, but the funds available from IHS have not increased accordingly.

The problem is particularly acute at Fort Peck because many of the problems for which our people seek treatment are related to alcohol abuse, which always increases in times of economic hardship.

And I can realize how this particular condition exists on other reservations as well as Fort Peck. The employment opportunities that are available at Fort Peck are not available on other reservations.

I would also like to call to the committee's attention staffing problems. The tribe strongly opposed President Reagan's efforts to eliminate funds for training and recruitment. Funds for these activities are just as important as funds for medical services in improving the health status of the Indian people.

We have had considerable difficulty in filling professional staff positions at the clinics, particularly for physicians. The long term solution to this problem is increased funding for training of Indian health professionals.

Over the short term, intensified recruiting efforts are needed. We are not satisfied by the recruiting efforts of the Billings area office, and are attempting to do some of our own recruiting, even though we do not have the resources. Funds under the reauthorized act should be used to improve and expand the Indian Health Service recruiting program.

The Fort Peck Tribes strongly oppose the recommendation by OMB Director David Stockman to require Indians to pay for IHS services. The foremost reason for our opposition is that the IHS service is part of the Government's trust responsibility to Indian tribes. As so stated in the very first section of the Indian Health Care Improvement Act of 1976, which states:

> **Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.**

OMB's estimate is far too high insofar as the collection of funds from companies insuring individual Indians is concerned. We are informed that it is based at least in part on the recent study of the number of Indians who have private health insurance.

The Indians studied lived in a metropolitan area in Oklahoma and were nearly all employed. Not surprisingly, almost 90 percent of these Indians had private health insurance. In Indian country as a whole, the figures are much lower.

On the Fort Peck Reservation we have insurance to a certain extent. Some of the individuals who are involved in the ranching and farming business have insurance on their own as well as those who are employed in our two industries on the reservation.

We provide insurance for these individuals as a matter of incentive to work in those particular industries. But for those individuals who are not involved in the ranching or farming operations or not employed in our industries, it is very difficult for them to secure insurance with the meager income that they have.

There is a final reason why the OMB proposal should be rejected. Realistically a means test would have to be used to determine whether and how much Indians should be forced to pay for Indian Health Service. This would require additional employees when you take into consideration that anytime additional work is required by any of the Federal agencies, the first thing that they think of is being top heavy, putting on additional staff and employees and not making the resources available down to the grassroots level where the actual need is and where it is most needed.

So as a result of the experience we have had in the past, we have realized that if this particular method is implemented, the Indian Health Service would be top heavy with employees trying to determine what individuals are entitled to free health care, and what individuals would be required to pay for health services. For these reasons we are opposed to OMB's proposal.

I would like to comment on the recommendations of the Indian Health Service Task Force on Contract Health Services. This report makes 24 basic recommendations, many of which would affect not only contract care, but all Indian health services.

The task force recommends that eligibility for Indian Health Service services be limited to tribal members. Some Indians who are not enrolled members have as much Indian blood as tribal members, but do not have enough blood of any one tribe in order to enroll. Others are eligible for enrollment by blood, but did not enroll before the applicable cutoff date. It would certainly not be fair to exclude those individuals from Indian Health Service.

We understand that some tribes are in favor of limiting eligibility to tribal members. These tribes should have the discretion to do so.

According to the task force report, Indian Health Service generally pays contract care providers whatever they charge. The task force estimates that if Indian Health Service paid for hospitals and physicians for contract care services at medicare rates, it could have $25 million per year, which could be used to provide additional services.

We would not object to a policy of computing reasonable payment rates in order to combat excessive charges by hospitals and physicians.

However, we see some possible problems in using the medicare payment method. Medicare charges a sizable deductible at the beginning of a hospital stay, and then after a certain period of time, the patient is responsible for 75 percent of the daily charge. Beginning with the 91st day, the patient is responsible for 100 percent of the charges.

Unless a medicare beneficiary has other insurance that will pay the charges medicare does not cover, he must pay these charges himself.

The Indian Health Service should adopt a policy that will give it the flexibility to pay a rate that will give Indians access to top-quality hospitals and physicians.

The task force has also recommended that Indian Health Service be divided into three priority groups. All needs for services in the top priority group would be satisfied before funds were provided for services in the next group and so on.

Certain types of services, including kidney dialysis and nursing home care, would not be included in the three proposed groups at all, but might be authorized at a later date if appropriations permit.

The report also does not present estimates of how many Indians would be left without any affordable source of health care if particular services were eliminated from Indian Health Service priorities altogether.

For services such as kidney dialysis, pacemakers, and all types of residential care, serious problems would result if Indian Health Service were prevented from paying under any circumstances.

To summarize, we cannot evaluate the service priority recommendation based on the information provided. If Indian Health Service does not have the additional information, it should obtain it, and if it does, it should be made available to tribes for their review.

In addition, we oppose a system that would prohibit Indian Health Service from paying for important medical services where there is no other source available.

Senator, this pretty much summarizes our testimony. I have also elaborated on CHR proposals. I have written numerous letters to you concerning our problems in relation to the CHR's and in my testimony I covered that to some extent.

I also made mention in my testimony of a proposed kidney dialysis program that we have instituted on our reservation. We are not having too much success in getting cooperation from Indian Health Service.

If there are any questions, I would be happy to answer them. Thank you very much.

Senator MELCHER. Along that line, Norman, you had 20 CHR people quit; is that correct? And, two of them are trained for dialysis?

Mr. HOLLOW. Right—three, isn't it?

Mr. DOKER. Two.

Mr. HOLLOW. Two? OK.

Senator MELCHER. What is the problem then? How many patients do you have that need kidney dialysis?

Mr. HOLLOW. I believe there are eight.

Mr. DOKER. Yes, eight. Two at home and six in Billings.

Senator MELCHER. Six in Billings?

Mr. DOKER. Yes; we did a feasibility study on home dialysis, which we are just getting finalized now.

Senator MELCHER. But you are having problems with home dialysis?

Mr. DOKER. No; we are going to have a home dialysis center at Fort Peck.

Senator MELCHER. Oh, you do not right now?

Mr. DOKER. No; we have the individual home dialysis.

Senator MELCHER. How come you have six up here? Is it because you cannot take care of them at home?

Mr. DOKER. Yes; because of relatives and such, you know, that take care of them. Some of them do work, you know, and it hinders their job and such.

Senator MELCHER. Well, where is the problem with the cooperation from the IHS?

Mr. DOKER. Well, it is in the study that we are doing. It costs more to bring them down here, you know, than to have the center locally. You know, it would save a lot of money.

Senator MELCHER. I see.

Mr. HOLLOW. There is an Indian Health Service building that is available locally, and the tribal council has proposed that that particular building be used to place this dialysis machine in, so that the patients can be brought there and take the treatment instead of being brought clear down to Billings. They can provide treatment right on the reservation level. This is the proposal the tribal council has submitted.

Senator MELCHER. Your letter of June 16th dealing with contract bidding will be made part of the record, along with your other testimony.

Mr. HOLLOW. Thank you.

Senator MELCHER. It is a good letter and good testimony Norman.

You feel rather strongly that the contract bidding procedure would cost more than if the health care available in the area were emphasized; is that right?

Mr. HOLLOW. Right.

Senator MELCHER. Does the tribe have any money coming from the Montana Indian Health Board.

Mr. HOLLOW. I believe they do, don't they, for delegation purposes?

Mr. DOKER. No; we are not a member of it anymore.

Senator MELCHER. You are not a member anymore?

Mr. DOKER. No, we are not.

Senator MELCHER. It is probably up to date then, if you don't have any money coming from them.

Very good testimony. Thank you both very much.

[The prepared statement and letter follow. Testimony resumes on p. 118.]

PREPARED STATEMENT OF NORMAN HOLLOW, CHAIRMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK INDIAN RESERVATION

Senator Melcher, members of the Senate Select Committee on Indian Affairs, fellow witnesses, and guests, my name is Norman Hollow. I am Chairman of the Assiniboine and Sioux Tribes of the Fort Peck Reservation in Montana. I have been Tribal Chairman since 1973 and have been a member of the Tribal Executive Board for 35 years. It is a pleasure to be here today to testify on health issues of importance to the Indian people at Fort Peck.

Congress passed the Indian Health Care Improvement Act in 1976. The findings Congress made as part of that statute presented a grim picture of health

and health care among the Indian people. The health status of Indians was far below that of other Americans, and the available services did not reach many of the Indians' most critical health needs. Although federal health services to Indians had produced some improvement in the situation, Congress found that inadequate and outdated facilities and equipment, a serious shortage of personnel, and insufficient services prevented truly significant advances.

I regret to say that Congress could make the same findings today concerning Indian health. As I will describe further in my testimony, staff shortages and inadequate facilities, equipment, and services are a fact of life on the Fort Peck Reservation. The progress that was made during the 1960's and 1970's has been completely halted since President Reagan severely cut the Indian Health Service budget, and indeed, the situation has deteriorated. In my testimony today, I will urge reauthorization of the Indian Health Care Improvement Act, and will also address other health issues of concern to the Fort Peck Indian community, including the recommendations of the Task Force on Contract Health Services.

A. THE FEDERAL HEALTH SYSTEM AT FORT PECK

To place my remarks in the proper context, I first provide a brief description of the federal health system on the Fort Peck Reservation. The Indian Health Service (IHS) at Fort Peck provides direct care at two clinics, one in Poplar and one at Wolf Point. Unfortunately, the clinic in Wolf Point—the largest community on the reservation—is very small and lacks X-ray and lab facilities. There are five physicians and four public health nurses on the clinic staff. Services provided include routine medical care, dental services, mental health counseling, and alcohol detoxification. In fiscal year 1982, outpatient visits to IHS facilities numbered 30,208 in Poplar and 15,947 in Wolf Point, for a total of 46,155 outpatient visits.

Contract care is provided at two community hospitals, one in Poplar and one in Wolf Point. When these facilities are not equipped to handle a particular problem, the patient is treated at a facility off the reservation, usually in Billings. There is a serious backlog of contract care cases on the reservation, particularly surgical cases.

The Tribes have assumed responsibility for several health care programs through Public Law 93–638. These are the community health representative program, audiology, optometry, and the WIC program. In addition, the Tribes are seeking to assume responsibility for health education, nutrition, and environmental health. Of the 52 employees in the tribal health program, 50 are tribal members.

B. INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION

The Assiniboine and Sioux Tribes strongly support reauthorization of the Indian Health Care Improvement Act. The goals of the Act were to promote better Indian health by eliminating the backlog in needed services, improving the training available to present and future Indian health professionals, and providing funds for construction and renovation of health and sanitation facilities as well as urban and rural health programs. All of these needs still exist, and therefore continued legislation is necessary if the overall goal—improved Indian health—is to be met. The federal trust responsibility to the Indian people requires the United States government to pursue this goal vigorously.

If the Act had been implemented as Congress originally intended, reauthorization might not even be necessary. Unfortunately, appropriations have fallen far short of the amounts authorized by the Act. This, combined with the overall cuts in the IHS budget Congress has made at the request of President Reagan, has meant that many tribes have not been able to "hold the line" in provision of health services, much less improve such services as contemplated by the Act.

We are particularly concerned over Congress' failure under Title II of the Act to appropriate funds to eliminate the service backlog and meet known but unmet health needs. In fiscal year 1978, the first year after passage of the Act, the appropriations were closed to the level authorized. But in fiscal year 1979, only $4 million in additional funds were appropriated out of $28 million that were authorized, and no additional staff positions were funded, although 495 were authorized.

During the past 3 years, the situation has been even worse. In fiscal year 1983, for example, no new staff positions were appropriated, although such positions

as necessary were authorized. $11.9 million in additional funds were appropriated out of $74 million authorized, but virtually all these funds went to the equity health fund and the transfer of alcohol programs from NIAAA to IHS. The primary purpose of Title II—to reduce the backlog and reach unmet needs—was ignored in the appropriations process. This particularly damaging at Fort Peck, where the backlog in contact care has reached crisis proportions.

Thus, although the need for reauthorization of the Act is clear, such action will be to no avail if Congress does not appropriate the funds. We urge the Select Committee on Indian Affairs to set authorization levels in which, if met, would significantly improve the health status of the Indian people over the next seven years. We pledge to work with the Committee to achieve appropriations that will accomplish the goals of the Act.

I will now describe for the Committee some of the pressing health needs on the Fort Peck Reservation. The existence of these needs on the eve of the Act's expiration-demonstrate that the Act must be reauthorized and properly funded.

1. Contract care

At Fort Peck alone, we would need over $300,000 in additional contract care funds just to eliminate our current backlog. As of last winter, we had 200 patients waiting for surgery, including for cataracts, orthopedic problems, and gall bladder problems. We also need additional contract care funds for problems caused or exacerbated by alcohol, including cirrhosis of the liver and diabetes. At present, virtually the only patients who have access to contract care funds are those whose conditions have deteriorated to the point of an emergency. At that point, of course, medical care is much more expensive.

The House Appropriations Committee has recommended a $26.2 million increase in contract care funds for fiscal year 1984, but recognizes that this would leave over $22 million in unmet needs for contract care. In light of the nationwide crisis in contract care, we recommend that contract care be addressed separately in the reauthorized Act, and that enough funds be authorized to eliminate the backlog within two years.

2. Mental health services, including alcohol counseling

We are simply unable to meet the demand for mental health services. The need for such services always increases during an economic recession, but the funds available from IHS have not increased accordingly. The problem is particularly acute at Fort Peck because many of the problems for which our people seek treatment are related to alcohol abuse, which always increases in times of economic hardship.

With one brief exception several years ago, we have had only three people on staff since the 1960's. We briefly had a fourth staff member, but when he left we were unable to secure funds to replace him. We need additional staff to meet the demand for these essential services.

3. Equipment and facilities

As mentioned earlier, the IHS clinic in Wolf Point is inadequate. It is very small and has no lab or X-ray equipment, which hampers swift diagnosis and treatment and creates problems for those without transportation to Poplar. We understand that the House Appropriations Committee has recommended $200,000 for construction of a new facility. We request your continued support for appropriation of these much needed funds.

We have experienced serious problems at the Poplar Clinic in securing repair and replacement of broken and outdated equipment. This includes everything from laboratory machines to dental chairs. IHS informs us that the delays and shortages are due to lack of funds. This situation should be rectified by funds under the reauthorization Act.

4. Safe water facilities

Many Indian families at Fort Peck have individual well systems. The water from these systems has a dangerously high level of chemicals, and in some areas solid waste and sewage has contaminated the water table. We need additional water treatment facilities, sewers, and septic tanks. Our attempts to secure funds for these facilities have been unsuccessful.

5. Staffing problems

The Tribes strongly oppose President Reagan's efforts to eliminate funds for training and recruitment. As the Indian Health Care Improvement Act acknowl-

edges, funds for these activities are just as important as funds for medical services in improving the health status of the Indian people.

We have had considerable difficulty in filling professional staff positions at the clinics, particularly for physicians. The long term solution to this problem is increased funding for training of Indian health professionals. Over the short term, intensified recruiting efforts are needed. We are not satisfied by the recruiting efforts of the Billings area office, and are attempting to do some of our own recruiting even though we do not have the resources. Funds under the reauthorized Act should be used to improve and expand the IHS recruiting program.

C. THE OFFICE OF MANAGEMENT AND BUDGET'S RECOMMENDATION THAT INDIANS PAY FOR IHS SERVICES

The Fort Peck Tribes strongly oppose the recommendation by OMB director David Stockman to require Indians to pay for IHS services. The foremost reason for our opposition is that health services are part of the government's trust responsibility to Indian tribes. As is stated in the very first section of the Indian Health Care Improvement Act:

"Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."

To require Indians to pay for IHS services would violate this responsibility. Significantly, in spite of the financial problems it faces, IHS does not support this recommendation, based in large part on the unique federal Indian relationship and the longstanding policy not to require payment.

Before the white man arrived, the Indians of the plains were relatively healthy people. With the advent of the reservation era, the Indians' health declined—in material part because of a forced change in lifestyle, malnutrition, deplorable housing, a lack of medical attention for the problems produced by these conditions. Even after the government assumed responsibility for these problems, it did not assign a sufficient number of physicians to the reservations, and the physicians were hampered in their efforts by inadequate equipment and facilities. Government schools were frequently overcrowded and unsanitary, causing further health problems.

During the latter part of twentieth century, the government has attempted to solve the problems it created. However, as the Indian Health Care Improvement Act indicates, the health status of Indians has remained inferior to that of their non-Indian neighbors. The government's responsibility to correct this sad situation has not diminisned, and it must not be permitted to shift the burden to the Indian people themselves.

We are informed by IHS officials that OMB's proposal was motivated in large part by its desire to collect from private insurers for IHS services. Many states prohibit private insurers from reimbursing federal facilities where the recipient of the federal services had no obligation to pay. In OMB's view, if IHS obligated Indians to pay for IHS services, it could obtain reimbursement from the private companies. OMB estimates that IHS could obtain nearly $30 million per year in this manner.

OMB's estimate is far too high. We are informed that it is based at least in part on a recent study of the number of Indians who have private health insurance. The Indians studied lived in a metropolitan area in Oklahoma and were nearly all employed. Not surprisingly, almost 90 percent of these Indians had private health insurance. Of course, in Indian country as a whole, the figures are much lower.

In any case, if the objective is to obtain reimbursement from private insurers, there is no need to impose a general requirement that Indians pay for IHS services. Instead, IHS could seek federal legislation that would supersede state laws prohibiting it from seeking reimbursement from private insurers.

There is a final reason why OMB's proposal should be rejected. Realistically, a means test would have to be used to determine whether and how much Indians should be forced to pay for IHS services. This would require additional IHS employees. If the means test is fair, the great majority of Indians would not have to pay for services—and the additional administrative costs would exceed the payments received.

D. THE RECOMMENDATIONS OF THE IHS DIRECTOR'S TASK FORCE ON CONTRACT HEALTH SERVICES

Senator Melcher, I would like to comment on the recommendations of the IHS Task Force on Contract Health Services. This report makes twenty four basic recommendations, many of which would affect not only contract care, but all IHS services. In my testimony today I will address several of the most important recommendations.

1. The task force's eligibility recommendation

The Task Force recommends that eligibility for IHS services be limited to tribal members. The Assiniboine and Sioux Tribes of the Fort Peck Reservation oppose this recommendation. On the Fort Peck reservation there are Indians who, although not members of the Tribes, are of Indian descent, hold themselves out to be Indians, and are recognized by the Fort Peck Indian community as Indians. The Tribes exercise civil and criminal jurisdiction over these individuals. In our view, these Indians should receive IHS services just as tribal members do.

Some Indians who are not enrolled members have as much Indian blood as such members do, but do not have enough blood of any one tribe in order to enroll. Others are eligible for enrollment by blood, but did not enroll before the applicable cut off date. It would certainly not be fair to exclude these individuals from IHS services.

We understand that some tribes are in favor of limiting eligibility to tribal members. These tribes should have the discretion to do so. President Reagan promotes the policy of giving the state governments more discretion in the administration of federal programs and also favors dealing with tribes on a government-to-government basis. In accordance with the President's policy, tribes should be given the discretion to use tribal membership as the criterior for eligibility.

2. Use of the medicare methodology to compute rates of payment for contract care

According to the Task Force Report, IHS generally pays contract care providers whatever they charge. The Task Force estimates that if IHS paid for hospitals and physicians for contract care services at Medicare rates, it could save $25 million per year, which could be used to provide additional services.

The Assiniboine and Sioux Tribes would not object to a policy of computing reasonable payment rates in order to combat excessive charges by hospitals and physicians. However, we see some possible problems in using the Medicare methodology. Medicare charges a sizeable deductible at the beginning of a hospital stay, and then beginning with the 61st day the patient is responsible for 75 percent of the daily charge. And beginning with the 91st day, the patient is responsible for 100 percent of the charges.

Unless a Medicare beneficiary has other insurance that will pay the charges Medicare does not cover, he must pay these charges himself. The Task Force has stated that hospitals would not be permitted to bill Indians for any amounts above the IHS rate. However, we fear that some hospitals, particularly those less dependent on IHS funds, would not accept this rate. This might be true of the hospitals in Billings, for example. This would reduce the number of hospitals available to treat our people, particularly those with complicated medical problems.

The same problem would arise with respect to physicians' services. Medicare pays only 80 percent of the "reasonable and customary" charges for these services. The reasonable and customary charge is frequently less than a physician's usual charge, and many physicians around the country bill their patients for the difference. According to IHS, physicians would not be able to bill Indians, and therefore some of them would stop treating Indian patients altogether.

IHS must not be permitted to adopt a payment system that will unacceptably reduce the number of providers available to treat Indian patients. We are informed that some providers have already agreed to accept the Medicare payment rates. IHS should study this matter further to determine how many providers would be willing to participate, and whether particular types of services—for example, hospital services for extended periods or sophisticated surgical services—will pose a greater problem. IHS should then adopt a policy that will give

it the flexibility to pay rates that will give Indians access to top quality hospitals and physicians.

3. Service priorities

The Task Force has recommended that IHS services be divided into three priority groups. All needs for services in the top priority group would be satisfied before funds were provided for services in the next group, and so on. Certain types of services, including kidney dialysis and nursing home care, would not be included in the three proposed groups at all, but "might be authorized at a later date" if appropriations permit.

The Task Force Report does not provide us with sufficient information to evaluate its service priority recommendation. Care for acute and life-endangering illnesses would be relegated to Category C, the lowest priority group. The Report does not analyze, based on probable appropriation levels and levels of demand for particular types of service, whether IHS resources would permit treatment of most, some, or very few of these illnesses. Category C includes treatment for acute conditions related to alcoholism and diabetes, as well as for cardiac problems and obstetrical emergencies, to name only a few. If treatment for such conditions would be rare or impossible under the priority system as proposed, then the priorities may need to be shifted—but we cannot make this assessment unless we have more information.

The Report also does not present estimates of how many Indians would be left without any affordable source for particular services if these services were eliminated from IHS priorities altogether. For services such as kidney dialysis, implantation of pacemakers, and all types of residential care, serious problems would result if IHS were prevented from paying under any circumstances. A flexible system would be preferable, but in any case, more figures are needed.

To summarize, we cannot evaluate the service priority recommendation based on the information provided. If IHS does not have the additional information, it should obtain it, and if it does, it should be made available to tribes for their review. In addition, we oppose a system that would prohibit IHS from paying for important medical services where there is no other source available.

4. Implementation plan

We understand that IHS is working to develop an implementation plan for the recommendations in the Task Force Report. This plan will shed further light on the effect the Task Force recommendations would have on IHS, and therefore we do not oppose its development. However, the plan should be considered a proposal on which tribes will have full opportunity to comment, not a final product. Tribes must not be excluded from any phase of the process of improving the delivery of health care to Indians.

E. COMMUNITY HEALTH REPRESENTATIVE PROGRAM

I also wish to bear witness to the value of the Community Health Representative program. Since he was first elected, President Reagan has sought to eliminate this program. We see no justification for this. Perhaps the President views the CHR program as little more than a "friendly visitors program" in which employees with no professional training stop in to chat with Indian families on the reservation. Nothing could be further from the truth. Our CHR staff provides important services to the Indian people at Fort Peck, and also serves as a vital link between the community and the public health nurses and physicians.

The CHR program at Fort Peck, which is contracted by the Tribes, has 20 employees. Over half of these individuals make home visits on the reservation. These include follow up for patients after surgery, initial assessment of possible health problems, administration of insulin to diabetic patients, and blood pressure checks. One of the representatives has special training in problems affecting the ear, nose and throat. She conducts monthly ENT clinics, and other representatives conduct clinics for patients suffering from diabetes and hypertension. In addition, two of the representatives have special training in renal dialysis, and operate the two kidney machines on the reservation.

All of the representatives are trained to take vital signs and to administer CPR and other emergency care. They become very familiar with the health status of the families on the reservation, and inform the public health nurses and physicians when their services are needed.

Three other representatives provide transportation to the clinics and to contract care facilities both on and off the reservation. Many Indians, particularly the elderly, would be unable to obtain medical care without such transportation.

I cannot emphasize enough just how valuable the CHR program is on a rural reservation where many ill Indians cannot easily come to medical facilities. The value of the specific services provided, for example those for diabetic and hypertensive patients, is obvious. Less obvious is the role the representatives play in encouraging our people to seek needed medical attention, educating them concerning proper diet and exercise regimens, and serving as their liaison with the IHS health professionals. We appreciate the committee's support for this program, and urge your continued support.

F. COMPETITIVE BIDDING

I have already expressed to Senator Melcher the Tribes' opposition to competitive bidding for contract care at Fort Peck. I again summarize our views on this subject for the record at this hearing.

The bulk of the contract care at Fort Peck is provided by the Poplar Hospital, which serves the east end of the reservation, and the Wolf Point Hospital, which serves the west end. If competitive bidding were instituted, the contract might be awarded to the hospital in Sidney, which is 70 miles away from the reservation, or Williston, which is 80 miles away. Transportation would be expensive, and would be dangerous for seriously ill patients. Our CHR program could not keep up with the demand for transportation, and no doubt many patients would forego treatment altogether.

We know how expensive it is to transport patients over long distances because we are already forced to do this when the Wolf Point and Poplar Hospitals do not have the facilities to treat them. It would be more cost effective to upgrade the facilities that already exist on the reservation.

Eighty percent of the services at the Poplar Hospital and 40 percent of those at Wolf Point Hospital are reimbursed by IHS. If these hospitals lost their status as contract care providers, they would almost certainly close. There would then be no inpatient services available on the reservation, even on an emergency basis. This would be a very dangerous situation. If necessary, the Committee should introduce legislation to allow both of these hospitals to retain their status as contract care providers.

G. PUBLIC LAW 93–638 CONTRACTS

As I explained above, the Tribes have contracted several health programs under Public Law 93–638, and have been quite successful. We plan to assume responsibility for as many programs as possible, and believe that IHS should fully support our efforts to do so.

However, we have found that IHS does not provide the proper level of support. When we seek to assume reponsibility for a program, we must identify all of the costs associated with that program so that we can calculate the contract amount. The IHS accounting methods make this process very difficult. Costs from different programs are frequently lumped together rather than being separated into line items. We need assistance to identify the costs "hidden" in this manner, but IHS has not been forthcoming with this information. IHS must be told to rectify this situation.

H. PROPOSED KIDNEY DIALYSIS PROGRAM

We currently have two kidney dialysis machines on the reservation, one at the Poplar Clinic and another in a patient's home. Only two patients can be served by these machines. There are six other Indians from Fort Peck who need dialysis, but because we do not have enough machines on the reservation, they have been forced to move to Billings. These patients need dialysis three times a week for approximately five hours per day. To serve all eight patients on the reservation, we would need four machines.

We would like to establish a dialysis center on the reservation so that patients needing this service would not have to leave their homes. IHS owns a house that would be suitable for this purpose. The cost to IHS would not be great because most of the patients are eligible for Medicare, and Medicare will pay the bulk of the cost. However, IHS has been very slow to cooperate with the Tribes

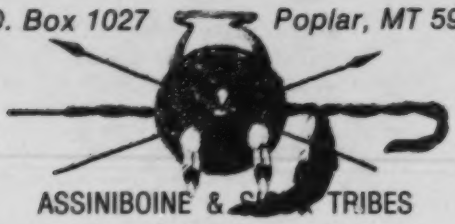
in this effort. The IHS administrators are unwilling to commit themselves to pay costs not covered by Medicare or to assist patients who are not eligible for Medicare. We are informed that IHS has paid these costs on other reservations, but there does not seem to be a uniform policy. This is a high priority item for the Tribes, and we request the Committee's assistance in resolving the matter.

Thank you for the opportunity to provide testimony on these problems, which are so vital to the lives of so many members of my Tribe. I would be pleased to answer any questions the Committee may have, or to provide any further information you desire.

for hg. record

FORT PECK TRIBAL COUNCIL

P.O. Box 1027 Poplar, MT 59255



ASSINIBOINE & S[illegible] TRIBES

June 16, 1983

Senator John Melcher, Chairman
Senate Select Committee on Indian Affairs
1123 Dirksen Senate Office Building
Washington, D.C. 20515

Honorable Senator Melcher:

The Fort Peck Tribes are on record opposing the contract bidding process. And at this time the Tribes have had nothing officially presented to them from Indian Health Service that will induce the Tribes to change their position.

As a recognized Tribal Government, responsible for the health care of the enrolled members, it is our position that the health care systems that are presently intact on the reservation should be improved, and not dissipated.

We are of the opinion that the bidding process will fractionalize the existing services which will cause confusion and place an additional financial burden upon the Tribes.

We have six communities on the reservation which depend on the present health care systems. The East End of the Reservation is serviced through the Poplar Clinic and the Poplar Hospital, and the West End is serviced through the Wolf Point Clinic and the Wolf Point Hospital. Now, if these services are changed it will create undue hardships, as well as financial burden on our people which will eventually become the responsibility of the Tribal Council.

Rather than going to a bidding process, Indian Health Service should consider maximizing the existing health care services on the reservation. Both Clinics, Poplar and Wolf Point, need updating in equipment and services provided. All personnel and staff positions should be evaluated to insure that adequate coverage for all necessary services and functions of our health care systems are on line. Also, an indepth review should be made of present policies and procedures which govern the processes and services that are provided through the health care systems.

There is no doubt that there are antiquated and burdensome bureaucratic procedures that require updating to meet the demands of the present day needs.

The bidding process in no way will save dollars. In fact, it will in the long run, be more expensive for the Indian Health Service. For example, if a 24-hour emergency medical service facility is what will become of this existing capability, then, emergency medical services support staff shall need to be hired. Transportation from this proposed crisis unit shall present a prohibitive cost element, as well as the imposition of intensification of an already emergency situation due to narrow icy road surface. There shall be added time for the responders to contend with because of the extended distances to Sidney, or other Hospital service centers. In addition, it will cost more dollars to the Indian people, and the Tribal Government. Taking away the service provided here on the Reservation in the foreseeable future, will create waste and reduce employment for our people.

We have an adequate clinic here in Poplar and a proposed new clinic for Wolf Point. We believe that it would be more sensible to use available dollars to improve those existing facilities to meet the needs of our people. There are many other services that can be provided for our people locally if concentration is directed to these proposed areas. One example; we need to provide an adequate Kidney Dialysis program for our people here on the reservation. The Tribes have already taken the initiative in this direction through the Tribal Health Program under the direction of Larry Burshia, but we need the cooperation and advocacy of Indian Health Service to ensure that this becomes a viable program.

The Poplar Community Hospital is vital to services for our people in the Fort Kipp Community, Brockton and Poplar. If this hospital is closed it will put a tremendous burden upon all these communities. In the cold winter months, when temperatures are well below freezing it is (often times) impossible to travel. If we are forced to go to the bidding process and our hospital is closed, it is likely that we will lose some of our people because of critical emergency conditions. It will be most inconvenient and risky to transport seriously ill patients any long distance such as to Sidney, or Williston, under hazardous conditions.

In conclusion, the Fort Peck Tribes' believe that the bidding process will seriously disrupt existing health care systems; cause a heavy financial burden upon the people and the Tribal Council; create waste and reduce employment; fragment services and continuity of direction! In the foreseeable future, it will cost more dollars and less services will be provided.

Our recommendation to the Indian Health Service is that they concentrate on maximizing the efforts here on the Fort Peck Reservation. We have existing health care systems intact, however, they need to be improved. The clinics need more modern equipment, as well as improved services. Bring the policies and procedures that govern the operations of the clinic up to date. Provide the technical assistance to the Tribes, which is their responsiblity, to ensure that adequate services are accessible, and provided in the least restrictive manner. And lastly, include in the overall program a plan to keep the Poplar Community Hospital open!!!

Norman Hollow, Chairman
Fort Peck Tribal Executive Board

cc: James Danielson, Billings Area Office/IHS
Herb Naugle, Review Committee

Senator MELCHER. John Myron, Tribal Health Board, Crow Agency. Is anybody here representing the Crows? Jessica Plain Bull? You are representing the Crow Tribe?

Ms. PLAIN BULL. Yes, Senator Melcher.

Senator MELCHER. Hold that mike very close to you there.

STATEMENT OF JESSICA PLAIN BULL, COMMUNITY HEALTH REPRESENTATIVE, ON BEHALF OF THE CROW TRIBE OF INDIANS OF MONTANA

Ms. PLAIN BULL. Senator Melcher, I am Jessica Plain Bull, CHR; and Mr. Ted Holcum, secretary of the Crow Tribe has requested me to present the testimony on behalf of the Crow Tribe.

It is the belief of the Crow Tribe, and in concert with the other tribes of the United States, that the provision of health services and health care is the responsibility of the U.S. Government. It is within this context that this testimony is presented.

It appears that the current, chaotic financial situation Indian Health Service is in is perhaps tied to the lack of or restricted availability of funds. Perhaps this is so, but the Crow Tribe makes the interpretation that the priorities of this great Nation need to be reassessed and redetermined.

Indian Health Service, as the primary organization responding to Indian health care needs, has long accepted the interpretation that medical problems confronting Indian people cover both the common medical kind, needing attention from an array of related health professionals, and also those problems arising out of the so-called social fabric of the community.

The conditions which existed 10 years ago, 5 years ago, and which provided just documentation for the creation of the Public Law 93–638 and Public Law 94–437 are still present today; limited education resources; lack of jobs; mutual suspicions between Indians and non-Indians. The scaling down of Indian Health Service is simply not the answer.

The Crow Tribe is hereby directing the attention of your committee to the following health concerns:

The CHR program, a valuable health service provided to Indian people is again scheduled for phaseout. The track record of this program has been established: An increase in patient visits to outpatient clinics for early detection and treatment; decrease in patient days at the hospitals; provision of services where there is a lack of resources.

This program must be refunded, and at a level no less than this past fiscal year. The staff of CHR programs throughout Indian country have not had a cost-of-living increase for the past 3 years. Our concern is for the program to continue. We further recommend that the line item identity and accountability be retained.

The health manpower benefits being provided to Indian students through title I of the Indian Health Care Improvement Act should be reauthorized since this is the only assured way of training and retaining Indian health professionals.

The health careers opportunity program, funded through the Federal Bureau of Health Professions has been instrumental in counsel-

ing, training, and recruiting Indian students into the health professions. The program within the Billings area serves the Indian students within the States of Montana and Wyoming. The Crow Tribal high school students from four high schools are active participants.

The contract health services task force report seems to have been assembled with little time for tribal review and comment. It appears that some of its recommendations are already being implemented by Indian Health Service.

The proposal to have IHS redefine eligibility downplays the fact that it is Congress who determines who is eligible for IHS services. The Crow Tribe believes that health services are an entitlement right of Indian people.

Consumer advocacy, participatory management, the means by which the interest, concern and involvement of Indian people has been maintained, obviously is not shared by this administration. As a result, the citizen advocacy groups which were fostered, maintained, and perpetuated have been effectively stifled by Indian Health Service.

There is a need to foster cohesiveness on an area and national level; therefore, the Crow Tribe recommends that funds be found, allocated, and distributed to area health boards and the National Indian Health Board.

The Crow Tribe hereby expresses sincere appreciation for the opportunity to provide this testimony. Any action taken by this committee and perhaps Congress is further appreciated.

Thank you. Are there any questions?

Senator MELCHER. Jessica, you are a CHR, are you not?

Ms. PLAIN BULL. Yes, I am.

Senator MELCHER. And how many of you are there?

Ms. PLAIN BULL. There are 19 of us at the present time.

Senator MELCHER. That is not enough, is it?

Ms. PLAIN BULL. It seems adequate, right now.

Senator MELCHER. It does seem adequate?

Ms. PLAIN BULL. Yes.

Senator MELCHER. Your testimony on this point is that, while IHS has not passed on any so-called cost-of-living adjustments in pay for 3 years, your opinion is that you want the program to continue. Is that shared by all of you, all the CHR people at Crow?

Ms. PLAIN BULL. Yes.

Senator MELCHER. Would you mind telling us what your pay is per day?

Ms. PLAIN BULL. Per hour?

Senator MELCHER. What do you receive per day when you are employed as a CHR?

Ms. PLAIN BULL. We make $4.40 an hour.

Senator MELCHER. You are paid $4.40 an hour?

Ms. PLAIN BULL. Yes.

Senator MELCHER. Do you generally get 40 hours a week?

Ms. PLAIN BULL. Yes.

Senator MELCHER. Do you get more than 40 hours?

Ms. PLAIN BULL. No; just the 40 hours.

Senator MELCHER. Do you have trouble getting reimbursed for the mileage you incur in your work?

Ms. PLAIN BULL. We keep track of our own mileage, and it takes about a week to receive the mileage that we put in.

Senator MELCHER. Do you use your own vehicle?

Ms. PLAIN BULL. Yes.

Senator MELCHER. What are you paid per mile?

Ms. PLAIN BULL. Twenty cents.

Senator MELCHER. That is standard for the Government. I think we went to 20.5, 20½ cents. Is it travel over highway, gravel roads, dirt roads——

Ms. PLAIN BULL. Mostly dirt roads.

Senator MELCHER. I want to compliment not just you, but the entire effort of the Crow Tribe. The CHR's have been very good. Most tribes point with pride to the work that is being done by the CHR people. It is extremely meaningful.

Ms. PLAIN BULL. Thank you, Senator Melcher.

Senator MELCHER. Thank you very much, Jessica.

Robert M. Harris, chairman of the Shoshone Business Council? Is Robert here?

We have both Robert M. Harris and Burnett Whiteplume of the Arapahoe Business Council. You are appearing jointly because your health care program is run jointly?

Mr. WASHAKIE. Right. Senator Melcher, I am filling in for Mr. Harris. My name is John Washakie, and I am a member of the Shoshone Business Council.

Senator MELCHER. Welcome, John. Who testifies first? Burnett, you go first then.

STATEMENT OF BURNETT L. WHITEPLUME, MEMBER, ARAPAHOE BUSINESS COUNCIL, ACCOMPANIED BY JOHN WASHAKIE, MEMBER, SHOSHONE BUSINESS COUNCIL

Mr. WHITEPLUME. OK. My name is Burnett Whiteplume. Our program is joint. The joint health committee has several concerns. And the first one is the Indian Health Service—or Indian Health Care Improvement Act.

We are in the position that we would like Congress to reauthorize the Indian Health Care Improvement Act because of the manpower scholarship program and the opportunity for Indian people to get graduate educations.

Also, we are concerned with the CHR program. It serves us. It does a job for us. And if it goes, we are going to be in a little bit of trouble.

In 1982 we had three infant deaths. And to me, that is a big problem, because I think one is too many.

We are concerned about the lack of coordination between the Indian Health Service and HUD over sanitation facilities. In other words, last year Indian Health Service had no resources for sanitation. There is no money in there for sanitation facilities in the housing part of it. So we are concerned that there is no communication, no coordination on who is going to be providing new services.

We are also concerned about the impact competitive bidding of hospital care will have in our area. We were notified on Wednesday that the process is going to be started. That is the first we heard about it since last year.

Senator MELCHER. Please, repeat that.

Mr. WHITEPLUME. Competitive bidding of hospital care. We were notified this last Wednesday, July 6, in our joint meeting, a joint meeting between the Arapahoe Business Council, the Shoshone Business Council, and the service unit director, to introduce our new physicians for this year beginning in July. And there was a note to be added that a bidding process will be starting quickly here.

We will be having a preproposal meeting July 19 at 9 o'clock in the morning at the service unit.

Senator MELCHER. Who would bid?

Mr. WHITEPLUME. From what I understand, there are four hospitals in our area that are eligible.

Senator MELCHER. Name them.

Mr. WHITEPLUME. The main one is Lame Deer Valley Regional Medical Center. The others are Natrona Memorial Hospital, which is adjacent to the reservation; the Riverton Memorial Hospital, on the reservation; and Lander is just outside the reservation.

So we are a little concerned about the impact it is going to have on your people.

We are also concerned about the contract health service budget. We have been on the life and limb category since 1981, which leads us to recognize that we have a lot of unmet needs.

We have a lot of people who are walking around that need some work done on them, and because we are short on funds with contract health service budget, the work is not being done. So we have a lot of unmet needs as far as contracting services.

As I understand, if we are hit with a catastrophic accident which will take a lot of money, we are going to be broke by September.

We are also concerned about access to health care. We have two health centers on the reservation. One is the Washakie, and we have the one in Arapahoe, which is about 25 miles east of Washakie, which is 8 miles west of Riverton.

Senator MELCHER. How far is Fort Washakie and Arapahoe from Lander?

Mr. WHITEPLUME. Fort Washakie is 16 miles from Lander and 22 miles from Arapahoe. Riverton is 8 miles to Arapahoe, and about 34 miles from Fort Washakie.

The Fort Washakie health center is available 7 days a week, and the health center is available only between the hours of 8 a.m. to 4:45 p.m. There are no facilities for housing of medical providers or any other facilities at Arapahoe. The headquarters is at Fort Washakie.

We are concerned over the impact of budget cuts on the health status of Indian people generally. The role of the Indian Health Care Improvement Act is to improve the health status, the level of the health. But we feel that just because our level has come up, there is no reason to quit trying to maintain a more acceptable level of health status.

Also, we are concerned about the communication problems between the service unit and the tribes. Since we have three entities working on our reservation and the Shoshone Business Council, the Arapahoe Business Council, and the Indian Health Service, it is a joint effort; and we are concerned about the communication among those three entities.

I think one of the problems that has just come up is the notice that we are going to be getting competitive bidding of health care.

Senator MELCHER. What would be the impact of that?

Mr. WHITEPLUME. On the bidding? I will let Mr. Washakie address that part.

Mr. WASHAKIE. Thank you. Senator Melcher, the impact of the competitive bidding on the Wind River Indian Reservation, we feel, would be tremendous. First of all, the Wind River Service Unit includes three Wyoming counties; Fremont, Hot Springs, and Sublet. And should a hospital from one of the neighboring counties submit a bid for the CHS funds, it is almost certain that they would get it. And we would have to travel outside of Fremont County to receive health care or hospital care.

Senator MELCHER. Where is most of the health care received now?

Mr. WASHAKIE. Traditionally Shoshones receive health care in Lander, and a large percentage of Arapahoe is served in Riverton.

Senator MELCHER. Is that satisfactory?

Mr. WASHAKIE. Yes.

Senator MELCHER. To your knowledge, is an Indian patient charged just as much as a non-Indian patient in identical bills?

Mr. WASHAKIE. I am sure that they are. In a survey that was run last year, Fremont County is ranged No. 3 in the State of Wyoming in hospital costs.

Senator MELCHER. Now, what does that mean, from the top?

Mr. WASHAKIE. Third from the top. And the other two counties are in the eastern part of the State.

So what we are saying is, if a hospital such as Thermopolis submits a bid, which is in Hot Springs County, they would receive it just on hospital costs alone. It would be the low bid.

Senator MELCHER. Then the impact is really a disruption of the care that you have now, or what?

Mr. WASHAKIE. They have already stated that it is about 16 miles to Lander, and 8 miles from Arapahoe. But when you think of Thermopolis, I would say that it would be 160 miles round trip and could go up to 200 miles round trip, if you are looking at the Shoshone people who are on the northern part of the reservation.

Senator MELCHER. I see.

Mr. WASHAKIE. One of the other things that I want to bring up in this area is that we know that approximately one-fourth of both hospitals' income comes from CHS funds. This competitive bidding, I think, is going to create a problem.

Any business—and both of ours are now businesses that are no longer funded by county commissioners and run by hospital corporations—any business which loses one-fourth of its income will more than likely be limited or one business will run the other out of business.

That is my opinion, of course.

Last week the COBE radio was running an advertisement to the effect that they were encouraging Lander residents to attend a public meeting on a proposed expansion of the Riverton Hospital. We really feel that since that confrontation did take place, it was not physical, but it was very oral and abusive and that we are just going to draw the two tribes into this conflict and into actually taking sides.

We see a lot of problems with this. Lander, of course, has the larger facilities and more specialists and more doctors, and you can probably guess that it is the county seat of Fremont County.

So past county commissioners have looked very favorably on funding those things in Lander. But I think we will really be drawn into choosing sides on this thing. It will be a split between the Arapahoe and the Shoshone Tribe. Because our people are traditionally used to receiving care in Lander and the people in Arapahoe are used to receiving it in Riverton.

To make it even more difficult, Mr. Whiteplume sits on the board at Riverton Hospital, and I used to sit on the board at the hospital in Lander.

Senator MELCHER. None of this originated with either of the tribes?

Mr. WASHAKIE. No; it did not. We were unaware of that until——

Senator MELCHER. Besides from Washakie?

Mr. WASHAKIE. Yes.

Senator MELCHER. Do you have more testimony?

Mr. WASHAKIE. I would like to address the CHR program. For some reason we kept hearing—at least at Wind River—that the CHR program was a taxicab service, I believe. And I would like to say, we do transport patients. But it is only on the basis of referrals from hospitals, clinics, IHS staff, or from senior citizens programs and schools, public schools and contract schools. That is basically how they transport them.

But I think even more so, we have 18 CHR's at Wind River. Twelve of those are specialists, and those specialists are in the area of community nursing. They assist the nurses with the diabetic clinics. Also, they make home visits to shut-ins. They do some screening. They do some health education in the home. We have only two for that, to cover the whole reservation. We have three people in our eyeglass department. They provide eyeglass service to all Indians on or near the reservation. It is really a cost-saving factor in that we have been able to operate this, because we have worked directly and contracted with an optical company and really cut the costs for our tribal members.

The other area is, we have two hearing aid specialists that provide screening clinics at public schools, and are also able to repair hearing aids. It is something that just not anyone can do. Our eyeglass people also repair eyeglasses.

We also have three dental assistants that assist the IHS clinics. And, I am not sure that those IHS clinics could operate without those three.

I am not sure that they have the money to fill those positions.

We also have two people that are specialists in environmental health. They maintain the solid waste disposal sites that were kind of out of control up until a couple of years ago when we put a 10-year plan on them.

They also apply pesticide for eradication of household pests. And they remove and dispose of dead animals. They remove and dispose of garbage for the senior citizens, or any disabled client.

And one of the other things that I think is really important, since we are unable to impose upon the Indian Health Service to provide doctors at any of our traditional and social gatherings, we man our

first-aid stations with CHR's. And each one of them fills in during a powwow, or during the sundance, or during the rodeo.

Sometimes, we are really concerned about the fact that some doctors can sit two blocks away and someone gets hurt at a rodeo, and they are unwilling to come over and look at them. Of course, we have to take them over and get a referral system, or get a referral and then we can take them to Lander.

This really causes a problem. Our ambulance service, of course, is from Lander. So I guess it is just a round trip for them.

The other things that they generally do—at least on our reservation—and there are six of them; they provide transportation for 450 clients per month, who are the elderly, or disabled. They have no other means of transportation.

I think it has been very important to us in the area of the CHR's. We need two more CHR's to handle the dialysis patients on our reservation. In the past we have put them in a nursing home, or Goshi, which is in Thermopolis, or down in Denver.

Of those patients, I think we have two left who are planning on coming back to the reservation. We really do not have anyone to take care of the dialysis part of it.

Thank you.

Senator MELCHER. Well, you have 18 CHR's now?

Mr. WASHAKIE. Yes; we do.

Senator MELCHER. I would say that I hope you get the two extras for dialysis, and I think every dollar that is spent on preventive health is saving $4 or $5 down the road. Preventive health measures is what you are doing.

I would not object to this taxicab label. If you are providing transportation to the elderly or the sick, or the CHR people themselves, you need somebody to ride back, that is fine. It also fits into preventive health. I see nothing at all wrong with it. It it excellent. If you do the commonsense things; the things you know are right, you will be doing exactly right.

I regret this criticism of the CHR program. I think it is partially because it is criticism by people who do not understand health delivery service in a rural area, particularly on an Indian reservation. I think it is criticism by people who do not understand quite often the language barrier and the reluctance of Indian people sometimes to talk to a strange physician or strange nurse. It simply overcomes that.

And it has been one of the most successful programs I have seen so far instituted that fills the bill of health delivery care and preventive health work on Indian reservations.

Do you have any more?

Mr. WHITEPLUME. I have a couple more. One of them is the concern over the active waste that is stored south of Riverton. We are concerned that this will have a long-term effect on our people since a great number of our people live in that area.

The final concern that we have is the eligibility requirements that have been talked about at the present time.

I would like to say, at least from the Arapahoe Business Council, we supported the efforts of the Montana Indian Health Board, and they owe us about $360. And I would like to support the efforts for the program in North Dakota, the INMED program.

And finally, I would like to say that I have some personal concerns I would like you to know. The first one is that I would support you in funding the master of public health program. This is providing training to Indian people to become part of the solution to solving a lot of problems that Indian people face.

Those are my personal interests or concerns.

Senator MELCHER. Burnett, you are a graduate of the School of Public Health in Hawaii?

Mr. WHITEPLUME. Yes. The University of Hawaii.

Senator MELCHER. Is that a master's program?

Mr. WHITEPLUME. Yes; it is. I was a scholarship student under the 43–714.

Senator MELCHER. How long ago was that?

Mr. WHITEPLUME. I graduated in May of 1982.

Senator MELCHER. That is very commendable.

Mr. WHITEPLUME. I have no more. Unless you have any questions for John or me.

Senator MELCHER. Burnett—I'm not sure what the funding of that act——

Mr. WHITEPLUME. In the United States there are 28 schools of public health. And of those 28, only six have Indian programs.

The University of Hawaii is one and the University of Washington, and the University of California, Berkeley, are others. And, there are a few others around that do have programs that are funded directly to the school.

Senator MELCHER. We will check on the status of that and see if we cannot help the program.

Thank you both very much for testifying today. We will take up this matter directly with the area office on the question of asking for competitive bids. We will ask them to respond to it.

[The prepared statement follows:]

PREPARED STATEMENT OF THE ARAPAHOE BUSINESS COUNCIL, SUBMITTED BY BURNETT L. WHITEPLUME, MEMBER

It is important to restate that alcoholism (and alcohol abuse) is our biggest health problem. Our concern is for the total health status of Indian people.

The need for Indian health professionals was recognized by the passage of Public Law 94–437. The need still exists because the process of training Indian health professionals has only just begun. It is ironic that such a valuable program is to be cut when its benefits are yet to be enjoyed. We support the reauthorization of the Indian Health Care Improvement Act.

Indian health care will not be improved by the elimination of the Community Health Representative program. In 1982 Wind River Service Unit experienced three infant deaths and one infant death already in 1983. We must improve on this experience by the use of our CHR's. The improvement of health care of Indians must continue with the efforts of the CHR program.

We are concerned over the apparent lack of coordination between IHS and HUD over sanitation facilities on new housing projects.

I am concerned with the impact that competitive bidding of hospital care will have in our area. The existing referral pattern will be changed and will cause confusion.

The Contract Health Service budget is in bad shape, and service is delivered only when life and limb depend on it. We are concerned that this is not improvement in the level of health care given to Indian people.

We are concerned with the operation of the CHS program and who has authority to approve payment of care received by Indian people at our local level. Our local level consists of 2.5 million acres with a service population of about 5,500 people. The people are of two tribes—the Arapahoe and the Shoshone.

Many of our activities are together or joint, which means that we have a Joint Business Council. Our health concerns are addressed by the Joint Health Committee. There are two clinics on Wind River Indian Reservation. One is at the Fort Washakie Agency headquarters where most of all services are located. The other clinic is located at Arapahoe about twenty-five miles east of Fort Washakie or about eight miles west of Riverton. Arapahoe has no Bureau of Indian Affairs activities, it has only the IHS Health Center. Access to the needed health care is limited by distance from headquarters and the absence of personnel facilities such as housing for medical personnel. Emergency and evening requirements are handled by Fort Washakie. A responsive communications network is needed to improve the access. A physician stationed at Arapahoe would save money that is used by Indian people at the Riverton Memorial Hospital emergency room. The CHS budget would not be depleted as quickly with a physician stationed at Arapahoe. The Arapahoe Clinic operates Monday to Friday from 8:00 a.m. to 4:45 p.m. only. The Fort Washakie Clinic is available seven days a week.

There are many concerns that are important for you to know. Some of them foremost on our minds are presented above.

PERSONAL OPINION OF BURNETT L. WHITEPLUME

My name is Burnett L. Whiteplume. I am a member of the Arapahoe Business Council. I am co-chairman of the Joint Health Committee.

My personal opinion is as follows: I am supporting the funding of the Master of Public Health Programs as well as those of the recruitment and training of undergraduates.

The loss of opportunity for further Indian graduate education means a longer period of time before Indian people can contribute and be part of the solutions to our health problems.

I am a graduate of the University of Hawaii School of Public Health. I graduated in May 1982. My education works for me on a daily basis. It is benefiting my tribe because I am in a key position to effect solutions to some of our problems.

Senator MELCHER. Our next witness is Jim McCann, Roosevelt County Commissioner. Please proceed, Jim.

STATEMENT OF JIM McCANN, COUNTY ATTORNEY, ROOSEVELT COUNTY, MONT., ACCOMPANIED BY JIM HALVERSON, CHAIRMAN, BOARD OF COMMISSIONERS, AND J. T. BROWNLEE, DIRECTOR, WELFARE DEPARTMENT

Mr. MCCANN. Senator Melcher, I am Jim McCann, county attorney of Roosevelt County, Mont., Wolf Point——

Senator MELCHER. Please let me correct this. You are speaking on behalf of the county commissioners?

Mr. MCCANN. Yes, Senator. We are on the Fort Peck Indian Reservation. And with me today and available to answer any questions are Jim Halverson, chairman of the board of commissioners, and J. T. Brownlee, director of the welfare department.

Senator, as you yourself have stated, recent actions by the Indian Health Service to use county funds for the payment of medical services before using Federal funds represents a dramatic change in the IHS program.

Statutorily and traditionally the IHS has been the primary resource for provision of health and medical services to all Indian people on the Fort Peck Reservation.

The departure from the tradition and the direction of IHS to look to local welfare agencies as the primary resource, and then secondarily to the Federal fund, is even more insidious than it may appear on the surface.

The most onerous aspect is that now indigent Indian persons are denied the access to IHS for their health care needs while the wealthier Indian persons do have access to IHS.

The policy appears to be that no Indian person shall be required to be responsible for his or her own medical care and they are told:

If you can't afford the care, go to welfare for it. If you can afford the care, come to us.

The administrative rules of Montana, under which the department of social and rehabilitative services must operate in making determinations of eligibility for county-funded medical services states, in part: Section 46.9.509.

County medical programs are to be considered only after all other medical assistance resources have been determined, and, where available, used. Resources include but are not limited to: Medicaid; Indian Health Service; Veterans Administration Hospital and program; health and accident insurance; crippled children's services; private health or accident insurance plans; industrial accident benefits; and pursuit of third-party liability.

County medical assistance shall not be available to cover medical services for individuals who are, or would be, eligible upon application for assistance through Medicaid.

This is not an arbitrary rule capriciously established at the whim of some bureaucrat. It is founded on sound policy that where a resource exists for the benefit of an individual, group or class, that resource must be exhausted before the county can be tapped.

The traditional Federal Government policy of providing medical care for Indian people flows first from the traditional role of the Federal Government to provide for the care and protection of the individual rights of the person and property of all Indians.

I may be altruistic in applying nobility to a Federal Government purpose, but I believe a secondary reason for that policy is that because there is no local tax base for generation of funds from trust and tribal lands, this is the Government's way of assuring the provision of services to Indian people in lieu of taxes.

Norman Hollow quoted one paragraph of this, but at the risk of redundancy, I have to recite from three short paragraphs of the Indian Health Care Improvement Act of 1976.

The Congress finds that Federal Health Services to maintain and improve the health of Indians are consonant with and required by the Federal Government's historical and unique legal relationships with, and resulting responsibilities to, the American Indian people.

The Congress hereby declares that it is the policy of this nation in fulfillment of its special responsibilities and legal obligation to the American Indian people to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

And the Indian people's growth of confidence in Federal Indian health services is revealed by their increasingly heavy use of such services. Progress toward the goal of better Indian health is dependent on this continued growth of confidence. Both such progress and such confidence are dependent on improved Federal Indian health services.

It appears, Senator, that the present administration has taken a notion to abrogate the mandate of Congress so eloquently stated and to fly right at your face and state, "No, we are not going to provide all the resources necessary to effect that policy and the confidence of the Indian people be damned."

Senator, all of chapter 18 of title 25 of the United States Code is an eloquent statement of the total health care needs of the Indian people and of the intent, purpose, and determination of the Federal Government to provide for them.

When I construe these statutes and the advised use of the word "provide," I see it to mean provide the dollars. It does not mean that some Federal bureaucrat will assure the provision of the service by coercive threats to county officials such as we have experienced.

In short, on behalf of the Indian people of the Fort Peck Reservation and the taxpayers of Roosevelt County, Mont., we strenuously urge the funding and enforcement of Public Law 94–437 and the provision of medical care as a primary budget concern of the United States for all of the health care needs of Indian people as outlined in 25 U.S.C. 1601.

Senator MELCHER. Jim, I think this is well stated. And I will tell you what my intent is; and the intent, I believe, of the Select Committee on Indian Affairs, the U.S. Senate, and I think the House also.

We fully intend for the Indian Health Service to collect from medicaid or medicare those costs that would legitimately fall under those two programs were it not an Indian patient.

In other words, a yardstick is: What is medicaid for? What is medicare for? And if the patient is an Indian, I think we direct them, rather plainly and simply, to collect from those two sources. Recapture whatever the dollars that would flow to those patients if they were not Indians. Also, not to do it through some roundabout means, but do it right between agency to agency.

This idea that somehow the Indian person is supposed to pay, and then make out a voucher claim or some sort of claim for medicare and be reimbursed that way is not only contrary to my belief, it would not be good practice.

I think, if I may use the term "that flies in the face of the intent of Congress," I think this actually does fly in the face of the intent of Congress.

I do not know whether to change the law or not. But even if we do not change the law, I am going to have IHS change their policy. They are going to have to change.

Mr. MCCANN. I think the law is quite clearly stated that they have that obligation. I really believe that they have been abrogating it for some administrative reason higher up than us.

Senator MELCHER. It is not very difficult to dream up a method of transfer for medicare funds and medicaid funds right there in Washington. We will pursue that as well; put that provision in the law. Apparently it is not being done at all. Health insurance programs should also be done there.

As Jim Kennedy testified earlier, that all the Indian people who are teachers at Blackfeet are covered by private health insurance programs, yet their medical care is from IHS, and IHS says recapture from the insurance company that which would be otherwise recaptured by anybody else.

Mr. MCCANN. We have the same problem.

Senator MELCHER. We want to see that corrected. But I think it is a point for IHS to arrange. They are the provider of service, and they should bill the insurance company and collect. If they are hampered by

law in that, we will straighten it out. I presume it will take an amendment to the reauthorization of this act.

But, it is not my belief that they are hampered by law to recapture directly from medicare/medicaid those funds that would be available. I think reading Montana law, which is very clear and understandable, is a good point. While this only affects Montana, I would assume that other States have similar statutes.

Mr. McCann. I am sure they do.

Senator Melcher. On behalf of the Indian Health Service, they may well tell us that the law is not clear. We thought it was clear enough, but we want to clarify it. We will set their language and incorporate it into this reauthorization bill. But, on medicare and medicaid, we want that straight right now.

Thanks a lot, Jim. Let us know of the pressure that is put on the Indian people who are on welfare rolls.

Mr. McCann. We will.

Senator Melcher. And recapture funds for IHS, or any other Indian——

Mr. McCann. We can do that; yes.

Senator Melcher. Thank you very much.

Mr. McCann. Thank you, Senator. I appreciate your accommodating us so generously. But we have a problem. We have a man that is traveling with us, we have an airplane waiting at the airport, and I was wondering if it would be possible to put Web Russell next, who represents the Montana Hospital Association. He told me he had about a 5-minute statement.

Senator Melcher. Yes; Web, please come forward now.

Mr. McCann. Thank you.

STATEMENT OF WEBSTER T. RUSSELL, EXECUTIVE DIRECTOR, TRINITY HOSPITAL ASSOCIATION

Mr. Russell. Thank you, Senator, I appreciate the change in your order.

I am Web Russell. I am the chief executive officer of Trinity Hospital Association. I am also here in place of Bill Leary, who was unfortunately unable to make it today. He asked me if I would speak not necessarily for the Montana Hospital Association, but in their place.

In the short time allotted I will briefly address our concerns in the utilization of funds, access to facilities, the impact of the bidding process, and lastly I will hopefully outline some solutions that we believe can be brought into place that will solve some of these challenges.

It appears also that I will be somewhat at odds with some of the people who have testified prior to me. I believe that all of us in the room can agree that there is access to some form of health care delivery system for the native American.

However, as far as I have been able to ascertain, there is neither a shortage of personnel, supplies, equipment nor facilities. And the redundancy of services, equipment and personnel, which, as you know, Senator, is legislatively and financially discouraged in the private sector through HSA's, and apparently is not discouraged in the Indian Health Service.

Local specialists: One thing that will be coming up soon, of course, is the lack of MD's in 1984 and 1985 who will be available to the Indian Health Service because their scholarship program has been discontinued.

Some of the other concerns: We have local specialists available within a very few miles of the two health clinics that I am aware of who are often bypassed for tertiary centers often hundreds of miles away.

A case in point is a young native American woman who had a potential ectopic pregnancy. They requested that she have an ultrasound examination to determine if she was indeed pregnant. She was sent all the way to Williston in her own car.

Physicians know that ectopic pregnancies can suddenly rupture. The problem was she could have traveled less than 3 miles, and had the same examination on the same day. If that was not possible, she could have traveled 23 miles and had the same examination with a qualified board certified radiologist there. And she was sent 100 miles in her own car. Hopefully there was no permanent damage from this.

Second, I was recently informed that the moneys have been allocated and approved for construction of a new 20,000 square foot clinic in Wolf Point. This clinic is to be used for medical and dental care facilities. A laboratory is to be built, and support facilities are to be added. To man this facility, the present staff is to be increased to 33, making the assumption that half of this projected staff is directly supportive of the delivery of primary medical care.

Also that they see 35 patients a day. That means that there is an average of one person for every two patients. If this was allowed in the private sector, the physicians would be bankrupt in less than 3 months. A general rule of thumb is about one person for every 8 to 10 patients.

The clinics with which I am acquainted have a ratio of about 1 to 8 patients. We do not count the physicians. If you do not count the physicians, it is about 1 to 11.

When the Indian health patient is not financially covered for nonlife threatening problems such as severe lacerations, blunt trauma to the chest or even fractures in the hospital emergency room, I question whether building of a new clinic is the most expeditious use of the funds available.

As to the access of the native American to health care facilities, I refer you to the two letters that I sent you, Senator, in June, concerning the emergent and obstetrical care. Obstetrical care is not accessible at this point in time to the western end of our Fort Peck Reservation. They are encouraged strongly to bypass Wolf Point and go directly to Poplar. If a patient is admitted to our emergency room, it is an act of labor on more than one occasion, as I noted in the letter to you, Senator. They have even been encouraged, through the efforts of IHS, to get in their car and drive the additional 15 miles.

Present IHS policies in that area, not only in the emergent areas, but in the respectable area, have placed us in a Catch-22 situation. That being we either take care of the patients and receive no reimbursement for this care or we follow the strict guidelines set forth

by IHS and possibly aggravate the medical condition that was required to begin with.

What really happens, to be quite honest with you, is that because of the philosophy of our hospital, and I am sure other hospitals like us, as well as the philosophy of the medical staffs involved, we will take care of the patient. We will not only take care of the patient, but the IHS budget will remain intact as it is being held down by its administrators at the expense of the hospital's fiscal liability.

Another proposed approach to reduce the cost of health care is that by competitive bidding. We have been led to believe that competitive bidding will be carried out in the true sense of the word.

We have also been told that the intent of this process is to reduce the number of facilities delivering this care through the Indian Health Service as well as to reduce the cost of care provided.

All of three hospitals on the Fort Peck Reservation and Roosevelt County offer the same basic services. On an all or nothing basis, one of these three facilities will be more.

Assuming that the disposable dollar turnover rate is between 2.5 and 1, the dollars lost to the affected community will be in excess of $1¼ million; therefore, not only will the community lose its hospital, it will certainly lose its physicians because there is no place for them to practice, and it will also have its economy severely impacted.

In my opinion, the effective competitive bidding will only serve to effect a short-term fix and will not address a long-term solution.

I believe that there are several cost efficient methodologies presently in operation, and I believe these methodologies will affect a long-term solution to the problems discussed here today.

I will present one of those solutions that I believe will meet the needs of the Indian Health Service, will increase the availability of care to the native American population, in the Fort Peck Reservation and other reservations, and will do so at cost effective methodology.

The primary approach to this sort of a problem has been the utilization of a PPO, which is, I am sure you know, Senator, a preferred provider organization. The hospital and/or physicians negotiate a discounted fee structure with the payer. In th[illegible]se the IHS.

This negotiated discount fee reflects sev[illegible]l items. One of them being a very rapid turnover in claims handling, as well as the elimination of the hospital bad debts in relationship to the IHS in this case.

The PPO concept brings with it a utilization for review process, which efficiently monitors the utilization of services, and also monitors the length of stay.

One of the things I am sure, Senator, you have been looking at closely when discussing the diagnosis related group approach to health care is the length of stay factor. Trinity Hospital through its review committee has reduced its length of stay to approximately 3.5 days. Compare that, as you know, to the 7 days with the national average. Utilization review does work and in the case of the preferred provider organization there is an effective means of controlling that length of stay.

The next item the PPO does, it rewards the cost efficient facility. The PPO concept assists in meeting the specific needs of the IHS primary care. And primary care is referred primarily to the private sec-

tor. The IHS would no longer have to go out and search for physisians. It would be handled through the private care sector.

Utilizing the private care sector, the Indian patient would have the ability to go to any one of the private sector physicians at any time.

Second, each primary care facility, at least those located in our area, has existing laboratory and X-ray services.

In the case of the laboratory, there is a distinctive economy of scale in its cost structure. This being true, there is a very distinct possibility that laboratory services could be provided to the IHS by local facilities at a cost equivalent to or less than reference labs.

Mr. Hollow this morning referred to the fact that there was a laboratory missing in the Wolf Point medical facility, and that is correct. There are no X-ray services. I question, however, the purchase or restructuring of that laboratory service when there was one less than 1½ miles away that already offers its private physicians services equivalent to or less than major reference laboratories.

Lastly, with the increased use of the private sector physicians, the hospitals could recruit subspecialties to their communities which in the long run would be less costly to the tribe as well as the IHS and to consistently transfer patients out. Not only does the patient have to be transferred out, but there is an inordinate cost placed upon the patient's next of kin in order to get to Billings, or to get to Williston.

Presently we have an ophthalmologist in Glasgow, Mont., that has expressed interest in traveling to our portion of the reservation to do surgery.

However, because ophthalmology cases are transferred out of the State in some cases, we cannot offer that service locally as much as we would like.

In summary, there is no doubt in my mind that a long-term solution that challenges my outline here today is possible. It will require a concerted effort on the part of the providers, the Indian Health Service and the tribes.

I ask in your deliberations you seek a long-term solution and reject short-term fixes. I ask also that you consider the PPO approach to delivery health care.

I, again, thank you for taking up your valuable time seeking input on solutions to our mutual concerns. If you have any questions, Senator, on the proposal, I will be more than happy to answer them at this time.

Senator MELCHER. Well, I do not think the method of asking for bids as stated in this copy of this notice from the Department of Health and Human Services, Indian Health Service, to the hospitals in the general vicinity of the Arapahoe/Shoshone Reservation is a very good method. I do not think it will save money. I just think it will cause all kinds of problems. Plus it would probably cost more money in the long run when you figure the transportation.

Mr. RUSSELL. I think, Senator, when you look at the fact that if a patient is going to have to travel 50 miles, he is still going to go to the local facility to give them care. The local facility is still going to give them care.

And if the patient is unable to pay, Senator, it is just going to do nothing more than push the cost back onto the taxpaying public, which

is ridiculous when you consider taxes are high. For a galibladder, for example, you have to go 85 miles in a car to seek hospitalization. They are just not going to do it. And rightfully so.

Senator MELCHER. I think even for programed surgery, they can do it this week or 3 weeks from now. It is not going to save money. I think the tests should only be if the hospital is an acceptable health facility, and charges the same for Indian as non-Indian patients. That is a test, period. To go beyond that, it would seem to me it would be complicating delivery of health care.

We have discussed this with Indian Health Service, and we will discuss it for as long as it takes to kill their scheme. I think they tried to do something like this in Montana.

Mr. RUSSELL. We would love to have them tell us what they are going to do, Senator.

Senator MELCHER. Well, I do not think they are going to do this in Montana. But, I am surprised they are doing this in this area.

We have discussed the PPO system, and they want to give new initials and new terms to what we are doing. It is all right with me. So, we will call it PPO.

But to go for a competitive bid seems like to me it would be like trying to buy a vehicle, or a piece of equipment. Health care is not of that nature.

Mr. RUSSELL. The PPO would still allow the two communities—for example, competitive bidding would certainly pit the two communities against each other. PPO would allow both facilities to get together and function together and maintain the quality of care and at the same time improve the access to the Native American. Because it would not be restricted to a specific clinic.

Senator MELCHER. We were looking at this a year or two ago in the northwest part of the State involving the Flathead Reservation, and the Indian Health Service delayed implementing what they proposed to do. And then in the interim, the Confederated Salish and Kootenai Tribes of the Flathead Reservation developed a scheme for PPO and submitted it.

We forwarded it on to the Secretary of Health and Human Services, and have a letter back from Secretary Margaret Heckler saying that she thought it was a good idea. And she says that the area office here, the Indian Health Service office in Billings has been working with the tribes.

So I think at that level, at the Secretary's level, it seems to find great favor. And I would assume that that attitude would sort of percolate downward to Indian Health Service.

As to this question of the clinic improvement at Wolf Point, we have discussed this with some people up at IHS. We are going to pursue it today at this hearing.

Some of these points on whether or not an emergency exists and a hospital or a physician in his own office takes care of an Indian patient, I do not want to hear an argument over that judgment of whether an emergency exists. Because it is not the place of this Federal agency to interpose their judgment on the practitioner, or the hospital, or the combination of the practitioner and the hospital if it is deemed an emergency for the betterment of the health and safety of this particular patient.

And if the judgment is made by the practitioner, I am going to be rather insistent that Indian Health Service not respond with this type of letter. Because it flies in the face of medicine where the practitioner makes that judgment, and the attending physician at the time is the only one that can make that judgment.

Mr. RUSSELL. In the case of that one patient, there could have been very, very serious——

Senator MELCHER. There could be permanent disability or loss of life.

Now, the point always comes in politics where you have to believe someone. And this happens to be political because it involves a Federal agency. And the only person to believe is the attending physician. And once having made that judgment, that judgment has to determine what the course of events are after that. Refusing to pay it is simply unacceptable.

I want to ask about the case you mentioned, the ectopic pregnancy.

Mr. RUSSELL. Yes, sir.

Senator MELCHER. Was that decision to go to Williston a decision of the patient?

Mr. RUSSELL. No, sir. She was a hospital employee. She knew that the vehicle was going to be there that afternoon. She asked the physician at that point in time if she could please come to Wolf Point or go to Poplar, either one. He said, "No, you've got to go to Williston." And they had the service there that afternoon.

Senator MELCHER. I do not agree with that either. And I do not think that should be the policy or practice of IHS. The practical commonsense approach would be to go to the closest available service. The wishes of the patient should be followed immediately.

Mr. RUSSELL. We believe that also. Especially in the case of the mother in labor. More than one time, as I addressed it to you in that one letter, the patient is told to please leave the emergency room, go to another hospital to deliver. The woman is in labor, why do they want to stick her in the back seat of a car to go to another facility.

I think, as I stated in that letter, I think we have that portion of the problem somewhat settled. Not totally.

Our concern is that there is still a feeling at IHS that they will not pay the attending physician if it is not an IHS physician. If we call in one of our private practitioners at 3 o'clock in the morning because an IHS physician is not available, and if we have only one in our area that is available that delivers children, and I do not think they are expected to be on call 365 days a year, 24 hours a day. The physician will come in, deliver the child, but he will not be paid for his time.

Senator MELCHER. That is outrageous.

Mr. RUSSELL. Unless they have changed their policy since I have last discussed it with them, which is possible.

Senator MELCHER. You brought it up, so we will pursue it this afternoon. The relationship with the IHS people at every level with people in the communities that work with IHS can be built upon and become a professional relationship premised on commonsense and mutual respect for the health care of the Indian people. To allow Federal regulation to impose itself in the care of that, it defeats the whole purpose of what all of it—either the private sector or in the Federal sector—suggests.

We will try to instill that at all levels, not only at this area office, but also in Washington. Dr. Rhoades is the director. We will deliver it to him, and he surely needs it. With the status of assistant secretary, perhaps he can deliver it clear throughout the entire IHS bureaucracy. We ought to have the latitude to opt on the side of the patients in accommodating their health care needs and not let Federal regulations get in the way.

Thanks very much.

Mr. RUSSELL. Thank you, sir.

Senator MELCHER. Without objection, I will place a copy of the correspondence from Mr. Russell and the letter from Margaret Heckler into the record.

[The correspondence follows:]

May 30, 1983

RECEIVED JUN 0 6 1983

The Honorable John Melcher
United States Senate
1123 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Melcher:

At the request of Trinity Hospital's Medical staff, I have been asked to bring to your attention the state of affairs concerning the present reimbursement policy of the Indian Health Services (IHS).

In July of 1982 IHS, in an effort to reduce outpatient cost, issued a list of Acceptable Emergency Situations(see attachment). These "acceptable emergency situations" are the only outpatient services that are cost reimburseable. Visits to the Hospital's Emergency Room for any other reason are not covered services.

Since the issuance of these guidelines, the Medical Staff of Trinity Hospital has set up a review system as a part of their Utilization Review(UR) Committee fuction. The Medical Staff's UR Committee is made up of a Board Certified Surgeon(a physician advisor to the state PSRO), a Board Certified Family Practitioner, a Radiologist, and three General Practioners.

The UR committee evaluates all denied IHS outpatient records. If, in their opinion the case represents an emergent situtation, the denial is appealed. As only 60% of all denied cases are recommended for appeal, we believe that the process we utilize is objective.

Even after such efforts, we find that the IHS method of reimbursement in this area is less than objective. The Hospital has been informed, that all patients who do not meet the Acceptable Emergency Situation guidelines be refered to the IHS Clinic during normal working hours. This places the hospital in a "Catch 22" situation, accepting substantial medical legal risk, or accepting financial loss thereby compromising its fiscal viability.

We believe that placing the Hospital or the physicians that serve it in the "Catch 22" position between potential litigation and financial risk serves no good purpose, for either the patient, provider, or IHS.

To accentuate this dilemma two cases come to mind.

A 22 month old child was presented at one of our physician's office. The child was in acute respiratory distress, as well as gagging and vomiting. Rather than take the time to explain to the mother that she was to take the child to the IHS clinic and risk further deterioration of the childs condition, the physician elected to diagnose and stabilize the patient. Upon stabilization, the IHS

TRINITY HOSPITAL ASSOCIATION 315 knapp st wolf point,mt 59201 406 653 2100

clinic was notified, and the mother was asked to take the child to the IHS clinc for further care.

The UR Committee reviewed the case and determined that this was an emergent situation and that immediate care was required. However, the IHS Billings Office was not in agreement with the UR Committee. I have enclosed, for your review, the reply of the Billings Office. You will note that the decision is based on regulation rather than on common sense and the review of five licensed physicians.

The second case involves a patient who received blunt trauma to the rib cage. Prudent medical practice requires evaluation of this situation as soon as possible to rule out pneumo or hemothorax (air or blood in the chest cavity). As the occurance was at night and the clinic was not open, this evaluation was done by the physician on call. Again the UR committee felt this was an emergent situation, however, the IHS was not in agreement.

The Hospital and its Medical Staff believe that patients presenting themselves to our Emergency Room in need of emergent care, should be seen. This action meets not only a long established philosphy, but also reflects the reality of medical legal liability.

We have been given little or no relief from IHS. IHS states the patient should be billed for all non covered services. To simply charge the patient and if unpaid take financial recource is also unrealistic. Our recourse via the trible judicial system is very limited, therefore the vast majority of cases end up as "bad debt".

We understand that the use of our emergency services in non emergent situations may result in "bad debt", however we are concerned when a denial is appealed on a medical basis and then the appeal is denied on an administrative basis.

We believe that hiding behind capricious regulations that have no bearing on medical reality is an inadequate and punitive response towards health care providers as well as to IHS recipiants who truely need emergent care.

We are asking that you assist us in correcting this situation.

Thank you for your time and consideration in this matter.

Sincerely,

W.T. Russell, MBA
Executive Director

cc: Trinity Hospital Medical Staff

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Health Services Administration

Billings Area
Indian Health Service
2727 Central Avenue
P.O. Box 2143
Billings MT 59103

APR 8 1983

Our Reference: CHS

W. T. Russell, Executive Director
Trinity Hospital Association
315 Knapp Street
Wolf Point, Montana 59201

Dear Mr. Russell:

This is in response to your letter dated March 17, 1983, regarding your appeal of the decision made to deny payment of medical costs incurred by Alyssa Buck Elk.

We have been in contact with the Indian Health Service (IHS) clinic staff at Poplar regarding the basis for their decision and they informed us that they denied payment because prior approval was not obtained for the non-emergency medical service and that the IHS clinic was accessible and available to provide the medical services she needed.

Our Contract Health Service (CHS) regulations require Indian patients to utilize an IHS facility when they are within 90 minutes driving time for any medical services they may require. Also, no payment will be made for medical care and services obtained from private physicians or facilities unless the following applicable administrative requirements have been met. In non-emergency cases, the Indian patient, or an individual or agency acting on behalf of the patient, or the medical care provider shall, prior to the provision of medical care and services, notify an authorizing IHS official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. In emergency cases, the Indian patient, or an individual or agency acting on behalf of the Indian, or the medical care provider shall, within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify an authorizing IHS official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services.

The decision made is correct and in accordance with our regulations and we, therefore, must confirm it.

If you do not agree with this decision, you may request a reconsideration by the Director, Indian Health Service, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. Any appeal to this decision must be made within thirty (30) days from the receipt of this letter.

Sincerely yours,

James Danielson
Director, Billings Area
Indian Health Service

June 27, 1983

RECEIVED JUL 0 5 1983

The Honorable John Melcher
United States Senate
1123 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Melcher:

First let me thank you for taking your valuable time to look into our concerns in the area of emergent care for IHS covered patients.

I have enclosed a letter sent to the IHS office in Poplar, Montana. It appears that we have part of the problem resolved in that the Hospital will be reimbursed for services rendered. The only problem that persists is that of non IHS physician reimbusement when the IHS physician is not available for delivery.

As a facility with a proactive management philosphy, we realize that short term fixes must give way to long term solutions. The mechanisms to reach these long term solutions are already available and operating within the private sector. We, as an institution, continually explore long term solutions to health care delivery in Roosevelt County. I firmly believe that through the cooperative efforts of the private sector, IHS, and proactive members of the Senate such as yourself, long term solutions can be reached.

If you or the Select Committee on Indian Affairs decide to consider alternative methods of health care delivery, I will be glad to provide you and/or the Committee with the information our management team has captured in the search for "a better way".

Thank you again for the valuable time you have already taken in our behalf.

Sincerely,

Webster T. Russell
Executive Director

TRINITY HOSPITAL ASSOCIATION 385 knapp st wolf point, mt 59201 406 653 2900

May 16, 1983

Vera Gibbs
Service Unit Director
Public Health Center
Box 67
Poplar, MT. 59255

Dear Mr. Gibbs,

It has been brought to my attention, through our Risk Management Program, that IHS is again requesting that all deliveries be sent to Poplar Community Hospital.

Since May 7, 1983 IHS has transferred three patients from the Emergency facility of Trinity Hospital to Poplar Community Hospital for administrative reasons. In one case, the patient had to be transferred back to Trinity Hospital because of the need for a "C" section secondary to fetal distress.

This is of grave concern to us as this type of transfer places Trinity Hospital in a potentially litigable situation.

If litigation is filed because of a death or the condition of the patient was compromised, and a transfer was a part of the total regimen, the transferring physician and facility will most commonly be held liable if the transfer was made for other than medically justifiable reasons. To relieve the responsibility of liability, the emergency or other acute care documentation must clearly set forth and show medical justification as well as show the appropriateness of the facility to which the patient is transferred.

This legal stance is supported in part by the decisions of Jones vs. City of New York Hospital for Joint Diseases, 134 N.Y.S. 2nd 779 (Sup.Ct.1954), Joyner vs. Alton Ochsner Medical Foundation 230 So.2d 913 (La.App. 1970), Black vs. Caruso, 9 Cal. Rptr. 634 (Cal.App.1960), and especially Hernandez vs. Smith 552 F.2d 142 (5th Cir. 1977).

In all the above cases, there was no documented medical need for the transfer, only an apparent administrative need. In all three cases, there was a physician with obstetrical privileges available for the care of the patients. In all three cases, the Hospital, its Medical Staff, and the transferring physician share a potential liability.

As it is inappropriate for IHS to encumber Trinity Hospital and its Medical Staff with a potential liability, we ask that you reconsider your policy of transferring patients in active labor from Trinity Hospital's EMS unless there is a medical necessity. We also ask that, as there may be an occassion when the IHS physician may not be available for delivery and as the attending physician assumes the potential liability and responsibility for the patient and child, that they be reimbursed for their services.

Thank you for your time and consideration in this matter.

Sincerely,

W.T. Russell
Executive Director

TRINITY HOSPITAL ASSOCIATION 315 knapp st wolf point,mt 59201 406 653 2100

July 15, 1983

Area Director
Indian Health Service
P.O. Box 2143
Billings Montana 59103

RECEIVED JUL 21 1983

Dear Sir,

Enclosed are documents which were denied payment and that the Medical Staff's Utilization Review Committee has recommended that Trinity Hospital appeal.

Each denied case is reviewed by the Medical Staff's Utilization Review Committee. This committee is composed of a Board Certified Surgeon, a Board Certified Family Practitioner, two (2) General Practitioners, and a Radiologist.

In each case, the patient's record is reviewed in total, and the comments of the attending physician are solicited. After reviewing each case, a decision is reached as to the emergent nature of the case in line with good medical practice.

Finally, documents for those cases recommended for appeal are signed by the Chairman of the Utilization Committee.

A summary of the cases that are being appealed are as follows:

Violet Dubois	Migrain Headaches - The review by the UR Committee determined the patient had recurrent migraine headaches. Her first visit was at 0105 July 1. At this time the clinic was closed. The attending MD did not feel the patient should be required to to wait eight(8) hours prior to receiving relief from her pain. On July 4th the clinic was also closed and medication was also administered for the same reason.
Willie Burland	Possible Tooth Abscess - The UR Committee of the Medical Staff determined good medical care requires that an abscess in the facial area can produce life threatening complications and therefore, should be evaluated as soon as possible.

We believe the Utilization Review Committee evaluated each case objectively, and therefore request that you reconsider these cases under your appeal process.

Thank you for your time and consideration in this matter.

Sincerely,

W.T. Russell, MBA
Executive Director

TRINITY HOSPITAL ASSOCIATION 365 Knapp st. west point, ne 68001 406 663 2600

25-642 0 - 83 - 10

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 29 1983

RECEIVED MAY 04 1983

The Honorable John Melcher
United States Senate
Washington, D.C. 20510

Dear Senator Melcher:

Thank you for your letter concerning the interest of the Confederated Salish and Kootenai Tribes of the Flathead Reservation in developing a contract proposal under the Indian Self-Determination and Education Assistant Act (P.L. 93-638).

We are aware of the tribal interest. I am pleased to tell you that the Billings Area Indian Health Service Office has been working with the tribes and is currently providing technical assistance to them in the development of a contract proposal. We will maintain our current arrangement with hospitals in the area for the provision of contract health care to assure that the interests of the tribes are not adversely affected and that access to good medical care is available.

I am sending a similar letter to Senator Max Baucus and Congressman Pat Williams.

Sincerely,

Margaret

Margaret M. Heckler
Secretary

Senator MELCHER. Art Rambo, Hill County Commissioner. I think Nancy Neibauer and Tony Haggener and David Rice are along also. Where is Art?

UNIDENTIFIED SPEAKER. Art is back there.

Senator MELCHER. Art, we have a telephone message for you.

Mr. RAMBO. Thank you.

STATEMENT OF DAVID RICE, DEPUTY COUNTY ATTORNEY, HILL COUNTY, MONT.

Mr. RICE. Senator Melcher, my name is David Rice, and I am deputy county attorney for Hill County, and I appear before you today on behalf of the Hill County Commissioners and the Hill County Department of Public Welfare.

We appreciate the opportunity to speak to you because a problem has recently occurred for us, as it is occurring for all other counties which have reservations within their boundaries, and recent interpretations by the Indian Health Service are causing us great consternation about the future expenditures we will have to make out of our county budgets.

I am not going to be redundant with what Jim McCann says, because he expresses some of the same concerns I do as to legal interpretations of Federal regulations. But I do want to indicate to you the county medical payments are supported by property taxes, and those budgets have increased exorbitantly recently.

In 1979 and 1980 Hill County spent $3,800 for county medical benefits. Already in 1982 and 1983, in April, we spent nearly $80,000. We have another $70,000 claim pending, and this does not include any of the claims for our reservation residents. Those claims are pending and have been submitted to us in the amount of about $101,000. So we have a substantial amount of claims waiting there.

We do not have any tax base upon the reservation to secure payment as we do on other property, so that is difficult for us.

We have also been currently ordered by the Montana Department of Social and Rehabilitation Service, by a hearing officer, to pay these claims because of interpretation of law by the Montana Supreme Court. And I refer to that in my letter.

And also interpretation by the Indian Health Service under 42 CFR 36.23(f), which they call the residual benefit clause. They use that to argue that the Indian Health Service ought to be a residual benefit and that Indian residents on reservations should exhaust their resources for medicare, medicaid, third-party payers, and then also exhaust the county medical benefits before they come to the IHS.

We are attempting to appeal the orders that we received, but we do not have great hope for success in the legal process within Montana, because of the precedent that we have seen.

So it is our contention that there is a need for legislative action to correct this.

Now, it has only recently come about that this has occurred. Because, as I indicated earlier, we have thus far not been paid any kind of medical benefits for our reservation residents as we have requested.

In fact, the claims just started coming in in about June 1982, and those claims are pending from that point up until now.

Now, the IHS has indicated, in hearings that they have participated in, that the shortage of funds is the reason for them turning to the county medical benefits. They said they have upgraded the training of their people and have identified county medical benefits as an alternate resource which they feel ought to be tapped before IHS funds are used.

The concern is that there really is not much of a needs test being used, and the application process is a little bit arbitrary. We have one instance in which IHS has authorized and paid for hospital care for a mother and child in one hospital, and then refused to pay for it in another hospital that they went to after initial treatment. And now we are facing a claim by that second hospital.

So we feel there is a need for clarification of the regulations, for modification of them, to require that the Federal Government continue to assume the responsibility which they have always had. This would relieve the counties of—already being financially strapped—further obligations.

And if that is not possible, to conceive some method to compensate them for these sources of unexpected claims.

In conclusion, we acknowledge our obligation to care for the medically needy in our counties. Our reservation residents have always looked to Indian Health Service for their health care. We expect the Federal Government should accept its responsibilities for that health care to its Indian citizens in a way that does not further burden the Montana counties.

I refer to some of the other matters which have been of concern to us, but I think that what we are saying, is that there has been an abrupt change of policy and attitude.

You will find in my letter that we have had an indication that this residual resource clause or rule similar to it has been around since 1956. And it is just now that it is being interpreted in the way it is and the claims are being submitted to us.

With that, I would conclude my comments and be available for any questions.

Senator MELCHER. When were you given the first solicitation to pay a bill by IHS?

Mr. RICE. I do not know when we actually received the claim. I assume it was sometime last fall, the fall of 1982. The date of service was in June of 1982. That was the date of service to that individual.

What is happening is that the IHS, in the contract with our hospital in Havre has indicated that the hospital will be paid for the claim by IHS, and then the hospital is expected to then pursue the matter against the county for payment, and then there is repayment back from the hospital from IHS.

So, we are actually engaged in a conflict between our hospitals and county rather than the IHS. But indirectly, the IHS is causing that because of their interpretation. And, it is a legal interpretation in the State of Montana, too, which causes great difficulty in changing this, as you well know.

Senator MELCHER. Well, first of all, the county would have to budget for this.

Mr. RICE. Pardon?

Senator MELCHER. The county would have to budget for such a payment?

Mr. RICE. Yes; they would.

Senator MELCHER. Do they have authority in the Montana statutes to so budget?

Mr. RICE. Well, they have authority to budget for a county medical plan. Our concern is the extent of it, how far is it going to go?

Senator MELCHER. There was no budget, though, for payment of any costs that would have normally been paid by IHS?

Mr. RICE. No; there was not.

Senator MELCHER. I have already stated my view on this. We will, of course, just pursue it with the area office personnel here this afternoon. We will also pursue it with the department in Washington and see on what basis they think they are entitled to that. I violently disagree with it, because I think then that it begins to break down any Federal responsibility for Indian health.

Mr. RICE. Well, that is our position. The county has not actually listed itself as one of the resources. They list medicare/medicaid and other matters. But their interpretation now they say is due to a lack of funds. Before, they would go to IHS.

Senator MELCHER. Well, let us see. Medicaid could be tapped?

Mr. RICE. Well, if the person is qualified; yes.

What we are dealing with are people who have actually supposedly been turned off of medicare/medicaid to third-party insurance, and rather than IHS taking responsibility, they are saying it is the county's responsibility before they would do that.

Senator MELCHER. I fail to understand this attitude. It would seem that on that basis, that David Stockman, or some other bureaucrat in the Reagan administration could determine that as a policy, there would be no IHS. We could nickle and dime it, but the county level would save the Federal Government close to $700 million in annual appropriations.

It seems to me to be less than realistic. I hope we can clear it up promptly. I do not want you plagued with this. I do not see how Hill County can possibly pay it.

Mr. RICE. Well, all of these claims are pending now. And, of course, with the decisions that have been coming down from hearings officers, we are continuing to get them. We can hardly stop the snow slide that is coming. Something needs to be done in the near future.

Senator MELCHER. We will attend to that. Thank you very much for bringing it to our attention.

Mr. RICE. Thank you, very much.

[The prepared statement and accompanying correspondence follows:]

PREPARED STATEMENT OF ARTHUR RAMBO, CHAIRMAN, HILL COUNTY COMMISSIONERS, SUBMITTED BY DAVID RICE, DEPUTY COUNTY ATTORNEY, HILL COUNTY, MONTANA

The Hill County Commissioners, who also serve as the Hill County Welfare Board, are extremely concerned over the recent interpretation by Indian Health Service officials concerning the Code of Federal Regulations titled 43-36.12, surrounding alternate resources for medical payment for enrolled on-reservation Indian people.

Indian Health Service officials in Montana are interpreting that County Medical is a prior resource before Indian Health Service pays. The County is very concerned over this new policy in that this means that County dollars would be spent before Federal funds are used, which is just the opposite of what other Federal programs do.

It is our recommendation that the Indian Health Service regulations should be clarified so that the care of the low income medically indigent on-reservation people should be the first priority of Indian Health Service funds.

On file in our local Welfare Department there are medical claims totaling over $100,000.00, which Indian Health Service is saying that the County is responsible for. The Welfare officials feel that this is only a small portion of the medical needs of low income indigent Native Americans.

We do not feel that this type of burden should be placed on the back of the property taxpayers of Hill County alone. The only mechanism that we have to raise taxes for the local Welfare Department is to increase the mill levy in which the property taxpayers of Hill County, excluding the reservation, would be responsible for paying.

It is the feeling of the Hill County Commissioners that this is a Federal reservation and should be the responsibility of the Federal Government.

Our recommendation is for the policy to be clarified so that County Medical is not a prior resource and that Indian Health Service funds should first be spent for the indigent medically needy person.

We would like to further recommend that the Indian Health Services should be based on financial need as well as medical need, which is not being currently done.

We urge this committee to take a closer look at these regulations so that Indian Health Services top priority is taking care of the medically indigent Native American.

We thank you for your time and urge you to explore this matter further.

Hill County Welfare Dept.

406/265-4348

321 Fourth Street
Havre, Montana 59501

June 1, 1983

RECEIVED JUN 0 6 1983

Senator John Melcher
Senator Max Baucus
Rep. Ron Marlene

RE: Indian Health Services

Dear Sirs:

The Hill and Blaine County Commissions as well as the local Welfare Agency is very concerned over a recent policy interpretation of Indian Health Services to consider County Medical program as an alternative resource to be used before Indian Health Service will pay. This means that the County tax dollars are being asked to be used before Federal dollars, which is just in opposition of the majority of the policies of other Federal programs.

We would like to request that your offices conduct an investigation to determine if it is congressional intent according to per attachment of the CFR Title 43-36.12, Alternate Resources, which is being interpreted that County Medical eligibility must be established before payment of Indian Health Services for residents of a Federal reservation. A fact to remember is that County Medical is strictly local County tax dollars being raised by local county mill levy.. Why should the tax burden be put just on those counties with Indian reservations?

I might point out that IHS payments are not determined by a needs test as all of our medical programs are. It appears that if this funding is being cut in Indian Health Services then the most needy should be helped by this program rather than helping everyone but the medically indigent.

Legal Services as well as the local hospitals are going through the Social and Rehabilitation Services Administrative process to get the counties to pay these medical bills. The County's stand has been that it will have to end up in litigation. This will cost Federal and State county dollars before any payment is actually made. It is hoped this matter could be resolved before this type of action.

It would be greatly appreciated if this matter could be investigated as soon as possible.

If you desire further information, please feel free to contact us.

Sincerely,

HILL, BLAINE & LIBERTY DEPTS.
OF PUBLIC WELFARE

Nancy Heibauer
(Miss) Nancy Heibauer
County Director III

5461
Art Rambo
Art Rambo, Chairman
Hill County Commissioners

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cial and personnel resources made available to the Service.

§ 36.12 Persons to whom services will be provided.

(a) *In general.* (1) Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program, and non-Indian wives of such persons.

(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he is regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the Medical Officer in Charge shall obtain from the appropriate Bureau of Indian Affairs officials in the jurisdiction information pertinent to his determination of the individual's continuing relationship to the Indian population group served by the local program.

(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

[21 FR 9933, Dec. 12, 1956]

§ 36.13 [Reserved]

§ 36.14 Care and treatment of ineligible individuals.

(a) In case of emergency, as an act of humanity, individuals not eligible under §36.12 may be provided temporary care and treatment in Service facilities.

(b) Charging ineligible individuals. Where the Service Unit Director determines that an ineligible individual is able to defray the cost of care and treatment, the individual shall be charged at rates approved by the Assistant Secretary for Health and Surgeon General published in the FEDERAL REGISTER. Reimbursement from third party payors may be arranged by the patient or by the Service on behalf of the patient.

Subpart C—Contract Health Services

SOURCE: 43 FR 34654, Aug. 4, 1978, unless otherwise noted.

§ 36.21 Definitions.

As used in this subpart:

(a) "Alternate resources" means resources other than those of the Indian Health Service contract health services program, available and accessible to the individual, such as health care providers and institutions (including facilities operated by the Indian Health Service), health care payment sources, or other health care programs for the provision of health services (e.g., medicare or medicaid) for which the individual may be eligible.

(b) "Appropriate ordering official" means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the contract health service delivery area in which the individual requesting contract health services or on whose behalf the services are requested, resides.

(c) "Area Director" means the Director of an Indian Health Service area designated for purposes of administration of Indian Health Service programs.

(d) "Contract health service delivery area" means the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of this subpart.

(e) "Contract health services" means health services provided at the expense of the Indian Health Service

from public or private medical or hospital facilities other than those of the Service.

(f) "Emergency" means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

(g) "Indian tribe" means any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(h) "Program Director" means the Director of an Indian Health Service "program area" designated for the purposes of administration of Indian Health Service programs.

(i) "Reservation" means any federally recognized Indian tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), and Indian allotments.

(j) "Secretary" means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

(k) "Service" means the Indian Health Service.

(l) "Service Unit Director" means the Director of an Indian Health Service "Service unit area" designated for purposes of administration of Indian Health Service programs.

§ 36.22 Establishment of contract health service delivery areas.

(a) In accord with the congressional intention that funds appropriated for the general support of the health program of the Indian Health Service be used to provide health services for Indians who live on or near Indian reservations, contract health service delivery areas are established as set out below:

(1) The State of Alaska;

(2) The State of Nevada;

(3) The State of Oklahoma;

(4) Chippewa, Mackinac, Luce, Alger, Schoolcraft, Delta, and Marquette Counties in the State of Michigan;

(5) Clark, Eau Claire, Jackson, La-Crosse, Monroe, Vernon, Crawford, Shawano, Marathon, Wood, Juneau, Adams, Columbia, and Sauk Counties in the State of Wisconsin and Houston County in the State of Minnesota.

(6) With respect to all other reservations within the funded scope of the Indian health program, the contract health services delivery area shall consist of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation.

(b) The Secretary may, from time to time, redesignate areas or communities within the United States as appropriate for inclusion or exclusion from a contract health service delivery area after consultation with the tribal governing body or bodies of those reservations included within the contract health service delivery area. The Secretary will take the following criteria into consideration:

(1) The number of Indians residing in the area proposed to be so included or excluded;

(2) Whether the tribal governing body has determined that Indians residing in the area near the reservation are socially and economically affiliated with the tribe;

(3) The geographic proximity to the reservation of the area whose inclusion or exclusion is being considered; and

(4) The level of funding which would be available for the provision of contract health services.

(c) Any redesignation under paragraph (b) of this section shall be made in accordance with the procedures of the Administrative Procedure Act (5 U.S.C. 553).

§ 36.23 Persons to whom contract health services will be provided.

(a) *In general.* To the extent that resources permit, and subject to the provisions of this subpart, contract health services will be made available as medically indicated, when necessary health services by an Indian Health Service facility are not reasonably accessible or available, to persons de-

OFFICE OF THE COUNTY ATTORNEY
County of Hill

312 THIRD STREET
HAVRE, MONTANA 59501
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RONALD W. SMITH
COUNTY ATTORNEY

DAVID G. RICE
DEPUTY COUNTY ATTORNEY

ELEN DRIVENES
DEPUTY COUNTY ATTORNEY

July 7, 1983

U.S. Senate
Select Committee on Indian Affairs
Washington, D.C. 20510
ATTN Senator John Melcher

RE: Indian Health Care Improvement Act

Dear Sen. Melcher:

On behalf of the Hill County Commissioners, I wish to present some comments to you for your consideration. Our county, as one which contains an Indian reservation, is being required under present interpretation of law in Montana to accept full responsibility for medical payment of indigent Indians who have previously been covered by Indian Health Services contract care. As this situation represents a radical departure from previous procedure, we are in hopes that clarification of federal law will result in a return to an assumption of this responsibility by the federal government. This would be beneficial not only to financially strapped counties, but also to our Indian residents who have relied upon and look to the U.S. government to meet their medical needs.

Since June of 1982, our county has been requested to pay $101,952.19 for hospital and doctor services. As we have not been asked to pay claims like this in the past, we are not prepared to cover these costs. To compound matters, an interpretation of law by the Montana Supreme Court in the case of County of Blaine v. Moore, in 1977, has required County Medical Assistance to be considered as an alternative resource which is to be exhausted before Indian Health Services will pay for contract care. Faced with this, and the shortage of federal funds, the Indian Health Services has been regularly referring Indian clients to our Welfare Department. While our county acknowledges its legal obligations to care for the medically needy, this abrupt change of procedure has us concerned about the future.

We have recently held hearings under Montana Administrative procedures, and been ordered to make payment for $12,410.25 in hospital and doctor charges. Although we have appealed these rulings, we don't have great hope that we will succeed in asserting that the federal government should pay the costs for our Indian citizens who have always been eligible for Indian Health Services payment. Faced with that, we appeal to you for assisting in a clarification of 42C.F.R. 36.23(f) or a modification of it to require that Indian Health Services not be considered as a residual resource but rather a primary resource. At the hearings we have had, officials of the Indian Health Services have admitted that although C.F.R. 36.23(f) or a similar rule has been in effect since 1956, they have just recently determined to refer previously eligible clients to us because of the lack of funds and recent training of Indian Health Services workers which has emphasized the search for alternate resources. By doing so, that federal agency is avoiding a responsibility which they assumed many years ago and forcing Montana counties to carry a burden they are not prepared to meet. Only legislative action will correct this inequity and we urge your attention to it.

Very truly yours,

David G. Rice
Deputy County Attorney

Senator MELCHER. Our next witness will be Suzanne Trusler, vice president of Morning Star Enterprises. I think Suzanne's husband, Tom, is with her, and counsel, Steve Brown. Is Steve here?

Ms. TRUSLER. No; but Stan is.

Senator MELCHER. Stan Kaldesac will represent counsel for Suzanne and Morning Star.

STATEMENT OF SUZANNE TRUSLER, VICE PRESIDENT, SECRETARY AND TREASURER, MORNING STAR ENTERPRISES, INC., ACCOMPANIED BY STAN KALDESAC, COUNSEL

Ms. TRUSLER. Mr. Chairman, my name is Suzanne Trusler, and I am the owner of Morning Star Enterprises of Lame Deer, Mont.

As a general contractor, Morning Star currently has construction projects in process totaling well over $5 million. In the past 5 years, my firm has completed a wide range of construction projects totaling nearly $10 million.

I cite these accomplishments not to brag, but to demonstrate the qualifications of my firm. Morning Star Enterprises is a 100-percent Indian-owned business, qualified since January 10, 1975, by the BIA to be considered for construction work under the Buy-Indian Act.

In 1975, with your strong support, the Congress enacted the Buy Indian Act. In 1978, the Indian Health Service promulgated regulations under that statute. These regulations provide that firms, like Morning Star, be given a preference in contracts for the construction of Indian hospitals. I have attached detailed information on the Buy Indian Act to my statement.

Morning Star Enterprises wants to build Indian hospitals. We know we can do it. Nearly 10 years ago we built the Lame Deer health facility, a 17,000-square-foot modern health facility designed to serve the Northern Cheyenne Reservation. That facility is operating today, and we are proud of the contribution we made in constructing it.

But our interest in building hospitals is not limited to the past. We want to build hospitals in the future. In fact, for the past 3 years, we have made repeated good faith efforts to make known our interest in building, through a joint venture, the new hospital in Browning on the Blackfeet Reservation.

On behalf of our joint venture, Morning Star let the Indian Health Service and the Department of HHS know of my firm's interest in and qualification for an Indian preference contract to build the Browning hospital.

Despite these repeated efforts, many of which are summarized in an appendix to my statement, the Department of HHS announced last month its intention not to solicit bids on the construction contract as an Indian preference.

This decision was made with absolutely no consultation with my firm and with an apparent disregard to Morning Star's qualifications to build the project under a proposed joint venture.

Pursuant to congressional inquiries, we learned that the HHS officials in Denver made their decision against the Indian preference for the construction based on the following supposed findings:

They said—and I've heard this for the last 10 years—they said that there was no qualified Indian contractor that exists that has the ex-

perience to build the Browning hospital. They said that the Blackfeet Indian Tribe opposes a joint venture to build the Browning hospital and wants to have maximum emphasis placed on hiring Indians to work on this project.

They said there was no Indian-owned construction firm that has adequate performance bonding capabilities to build the Browning hospital. They said the phased funding of the proposed project is not conducive to a negotiated bid and/or an Indian preference.

The deadline posed by the end of the fiscal year, September 30, 1983, cannot be met if an Indian preference building contract process is pursued.

And as I said, these are things I have heard for the last 10 years.

By way of rebuttal, I offer the following counterarguments that I would like to have a real opportunity to prove:

Morning Star is capable of building a project of the size and type of the Browning hospital. The Blackfeet Indians are not opposed to a joint venture according to conversations I had earlier this week with Earl Old Person, the chairman of the Blackfeet Tribe.

Moreover, a serious examination of Morning Star Enterprises will demonstrate that we hire a maximum feasible number of Indians on our construction projects. For example, we are currently building a $1.4 million waste water treatment plant next to the Blackfeet Reservation, and over 75 percent of the workers hired on that project are Indians.

The joint venture I propose with the Bruce-Andersen Construction Co., has a combined performance bonding capacity far in excess of the cost of the hospital to be built in Browning.

The multiyear phased funding aspect of this project has absolutely no bearing on whether this contract should be subject to the requirements of the Buy Indian Act and the regulations issued by HHS under that act.

The fiscal year deadline of September, as Jim Kennedy mentioned earlier, can be met just as easily by letting this contract through the Indian preference process called for currently by HHS.

Moreover, I wish to emphasize that we have no intention of delaying this project. We never do. The expectation that it will be delayed by following an Indian preference procedure is not justified.

Indeed, I guarantee to you, on my word of honor, under oath as an American and as an Indian businesswoman, that my firm will not cause any delay to this project, provided that Federal officials in Denver do not impose unnecessary obstacles to my firm in the conduct of its work.

Before closing, I would like to spend a few minutes on the subject of joint ventures under the Buy Indian Act. There has been some controversy about non-Indian companies using Indian companies as fronts in dealing contracts under the Buy Indian Act. I personally have observed cases of this type, and I deplore them. If the Buy Indian Act is to be respected by the public, the contractors who rely upon this act must respect it, too.

There are several set-aside programs administered by the Government for the benefit of minority contractors. Some of these programs have been abused in the past and corrective measures have been taken by Congress.

I believe that corrective measures should be taken with the Buy Indian Act to insure that joint ventures to build Indian health facilities are real and not shams. We need these changes to insure that Indian contractors run their joint ventures and benefit accordingly. In short, we need these changes to insure that the Buy Indian Act achieves the goals established by Congress.

One final point before concluding. I do not enjoy criticizing HHS's Regional Office Facility and Engineering Construction in Denver, known commonly as ROFEC. Who can blame me for my reluctance to criticize ROFEC? Much of my firm's business passes over the desks of ROFEC officials.

However, I feel compelled to say that I have a growing suspicion that big contracts awarded by ROFEC go to one of two types of contractors: either to large, non-Indian firms, or to sham joint ventures controlled by large, non-Indian owners. I believe that that pattern exists and I think it is wrong.

I have been told that Federal contract officers do not like the Buy Indian Act because they believe it retards competition, raises construction costs, delays projects, and results in inferior projects.

I disagree strongly with these prejudices, and I call upon you to ask any questions about Morning Star Enterprises in this connection. The owners and employees of Morning Star Enterprises pride themselves in having a business thaat builds quality projects on time and within budgets.

In light of the above, I respectfully request you and the committee to consider the following actions: No. 1, to call upon the department of HHS and ROFEC to give my firm and any other firm similarly situated a real opportunity to prove the arguments I have made in this statement. No. 2, in the event that I am successful in proving the truth of the arguments made in this statement, I would hope that you and/or the committee would call upon ROFEC to have the construction of the Browning hospital bid for under Indian preference procedures. No. 3, to develop amendments to the Buy Indian Act that would preclude sham joint ventures by strengthening qualification requirements.

I want to thank you, Senator, for giving me the opportunity to testify before you today.

Senator MELCHER. Are you submitting a bid?

Ms. TRUSLER. The bid opening has not been advertised quite yet. The plans are not ready at this time, as I understand it. As of now the ROFEC in Denver has stated that it is not going to Indian preference for the reasons that I just cited. And I would like to have an opportunity to discount what they have said.

Senator MELCHER. Jim Kennedy said they were going to open the bids August 19. They must have advertised for bids.

Ms. TRUSLER. They advertised for what is called the preconstruction conference, and that is where interested contractors—that is at this time non-Indian contractors—can go and view the site. After that, then they will advertise for bids.

But what I am afraid of, Senator, is that if it does not go Indian preference, what is going to happen is that two Montana contractors, one Indian and one non-Indian, are going to lose out on another project as has happened in the past.

We have had St. Pat's Hospital in Missoula go to an out-of-State contractor. We had St. Vincent's go to someone in Missouri. We have had Deaconess and St. Pete's Hospital both that have gone to out-of-State contractors, and I just feel that this is the same pattern, and this is what is going to happen again. Our county cannot stand it.

Senator MELCHER. Suzanne, Jim Kenney said they are going to open the bids August 19. Is he incorrect?

Ms. TRUSLER. He may be right, but the project has not been advertised yet for us to get the plans.

[Mr. Kaldesac conferring with Ms. Trusler off the record.]

Ms. TRUSLER. Right, they have advertised it, like I said, for the preconstruction—well, it is a job site visit, but they probably have not advertised for——

Senator MELCHER. Did Bruce-Andersen Construction and Morning Star as a joint venture attend that conference?

Ms. TRUSLER. We will attend it.

Senator MELCHER. I thought it was held?

Ms. TRUSLER. It has not yet been held.

Senator MELCHER. Stan, you met with the Department officials in Washington in HHS on this. What did they tell you?

Mr. KALDESAC. They told me, in effect, Senator, what Suzanne Trusler has just told you, that they had an initial meeting with Mr. Al Peter, who is director of facilities engineering. He did not know much at that time about the project.

He promised that he would look into it. He called me the middle of the following week after having contacted the Denver office, and he told me that the Indian preference option was rejected for the reasons that Ms. Trusler just told you.

Senator MELCHER. Well, will Bruce-Andersen bid on this regardless of whether it is a joint venture or whether it is Indian preference?

Ms. TRUSLER. I cannot answer for him. My assumption is that he will. He certainly has the capability.

Senator MELCHER. Does he build all over the world?

Ms. TRUSLER. All over the world.

Senator MELCHER. So he loses a contract in Missoula, and he loses a contract somewhere else out of State? What does that say? He must be bidding high.

Ms. TRUSLER. I cannot answer that. Our interest in a joint venture——

Senator MELCHER. Nobody is in the business of contracting to leave money on the table.

Ms. TRUSLER. No.

Senator MELCHER. But that must be the case. He must have bid higher than the competition did.

Ms. TRUSLER. Well, if he has traveled all over the world—of course, in my opinion, if he bid closer to home, he would certainly have a better bid than going up to Alaska and then competing against local contractors there.

Senator MELCHER. Well, there are a couple things here. As Jim Kennedy said this morning, the application for that hospital first occurred 24 years ago. It has worked its way to the top a couple of times and been shoved to the side and would have been shoved aside

again this year if it were not for the action of Congressman Yates who was approached by HHS, or IHS. They wanted to use the money for pay increases for staff.

I do not know whether they are correct in saying that an Indian preference is applying for this or not. But we cannot allow anything to interfere with the process of clearing this up, because if it is slipped aside again for another year, we will not know if we will get it back again next year, or the year after, or the year after. Then another generation goes by and the people are without a hospital.

We will talk to them. If their interpretation of the act is correct, I presume you could submit your bid anyway.

Ms. TRUSLER. But that would disregard the fact that ROFEC is continuing to ignore Indian preference. That is what I want to impress upon you today.

Senator MELCHER. We will review that carefully with them. We have only about 6 lawyers on this committee. Maybe that is too many. But they have some expertise in discussing this with them.

You raised some very dramatic points here. Indeed, if they are true, if this is subject to Indian preference, there can be only two things for us to consider: why the department did not use it, and second, if there needs to be some revision in the law.

I do not know that there needs to be. I am merely curious. On a contract of this nature, where you are going to be in a joint venture with a recognized—at least I recognize Bruce-Andersen as a very successful, qualified, profitable contracting firm, which does a lot of work around the United States, and I suspect, in other countries as well, it would indeed generate the capability of having the winning bid with Morning Star.

I am well aware of your qualifications. I think, generally speaking, you can probably outbid most of the people. You do not need Indian preference. I do not think Morning Star needs Indian preference. I do not begrudge the fact that that helps Morning Star to become an entity that is recognized, that is not only capable, but very accomplished.

You have proven exactly what the preference for Indians on contracts is designed to do, to permit the entry into the business world of Indian contractors, and, for that matter, minority groups.

We will have to take very seriously the point you have raised, because the buy Indian requirements are in the law. We are going to have to have a very heart-to-heart talk with them. But since they have done this formally, it does not seem to be anything but a deliberate act. If it is arbitrary, that is separate. We will have to thrash that out with them.

I would encourage you by all means to bid on it, with preference or not. I think you might be the winners in the bid letting.

From what I have heard today, I do not think that we are going to be in a position to ask them to delay and then start the process over again. Because, I feel that they have already gone so far that to start the process over would delay the project for at least another year.

Ms. TRUSLER. No; I do not think at this point that it would.

Senator MELCHER. You do not think so?

Ms. TRUSLER. It is not a wild assumption. I just do not think if Indian preference were required, regardless if it went to some other In-

dian company, that it would delay the project. In fact, I think it would speed it up.

Senator MELCHER. Well, if they are truly going to open bids on August 19, which is only 6 weeks from now, that is——

Ms. TRUSLER. No contractor, to my knowledge has the plans and they must be reviewed for at least 30 days. I have not seen where we can pick them up.

Another point I would like to make—I guess I had kind of forgotten it—is why did ROFEC give Indian preference to an architectural contractor, and ignore giving Indian preference to general contractors?

Senator MELCHER. That defeats all commonsense, if that would be the case.

Mr. KALDESAC. That is the case. They put out the architectural bid on Indian preference, but not the general. And it was awarded as an Indian preference award for the architectural work.

Senator MELCHER. Who got it?

Ms. TRUSLER. Page Warner, who, to my knowledge, was a non-Indian architectural firm and is now an Indian firm.

Senator MELCHER. Page Warner is an Indian firm now?

Mr. KALDESAC. They received the award under Indian preference.

Senator MELCHER. Now, wait a minute. Can Indian architectural firms only bid on Indian preference?

Ms. TRUSLER. Sure.

Senator MELCHER. Nobody else?

Mr. KALDESAC. Or alternatively, Senator, it could be a joint venture. But again, the controlling partner in the joint venture, as in the Morning Star and Bruce-Andersen joint venture, has to be the Indian contractor, the Indian architect.

Senator MELCHER. The majority would have to be Indian?

Ms. TRUSLER. Right.

Mr. KALDESAC. The lead party, the controlling party who receives the——

Senator MELCHER. I think this needs review. Page Warner as a majority Indian has changed.

Mr. KALDESAC. If I could just interject one more thing, Senator, to put this in perspective. In one of the enclosures that Ms. Trusler provided, in December of 1980 her firm contacted ROFEC proposing at that time a joint venture with Morrison-Knutson. Now, of course, the joint venture is with Bruce-Andersen.

Over this 2½-year period, Morning Star has said, "We want to joint venture the project." I was told by the people in ROFEC that they did not consider joint venture possibilities at all because of what they allege and what we all agree are in some instances misuses of the Buy Indian Act in joint ventures.

Senator MELCHER. There could be. You are absolutely correct.

Mr. KALDESAC. They could be, as a common principle, Senator, but I do not think that ROFEC is willing to admit that Morning Star is a front company for Bruce-Andersen, Morrison-Knudsen, or anyone else. They could easily ascertain the bona fides of the joint venture. They did not choose, to my knowledge, to look into whether Morning Star's would be a bona fide joint venture.

I think that is where the problem is, and that suggests the larger problem Ms. Trusler raised of the Buy Indian Act and how it is being administered.

Senator MELCHER. Do you know, Stan, of a procedure by which they can review a joint venture to demonstrate that it is a bona fide joint venture?

Mr. KALDESAC. They could certainly require that any potential joint venture make the proper showings to comply with the regulatory requirements.

Senator MELCHER. Let me restate my question. I think you said a bona fide joint venture would comply with Indian preference?

Mr. KALDESAC. That is very easily done. The requirements of a bona fide joint venture are spelled out in the Federal regulations in the area. That is not a problem.

Senator MELCHER. Have they contacted you? They would just about have to, to examine that?

Mr. KALDESAC. Certainly. And Morning Star has done work for ROFEC in Denver. It is not an unknown quantity.

Senator MELCHER. I noticed that.

Ms. TRUSLER. The Lame Deer health clinic went through ROFEC.

Senator MELCHER. True. We will pursue it with them. But let me ask again, can you actually work up a bid in 30 days or less?

Ms. TRUSLER. That is what they are asking everyone to do. I might stress one final point before finishing, Senator, and that is, I know if it goes to a non-Indian firm, that the Browning people will not get their people hired. The unemployment will stay as high as it is up there now. And I know if we, if Morning Star succeeds in getting the project, that we will definitely hire Indian people.

Senator MELCHER. What do you feel would be the difference in the bid? Total price?

Ms. TRUSLER. Total price? I cannot say. It is all competitive bidding. But generally speaking, more non-Indian firms do not hire Indian people. That is history.

Senator MELCHER. You say you would hire 75 percent Indian. Just for my information, would this project be in the nature of maybe a $10-million project?

Ms. TRUSLER. Yes.

Senator MELCHER. On that type of project, how many carpenters, for instance, would you be hiring at one time?

Ms. TRUSLER. Without looking at the plans myself, that is difficult to answer, but I would say total employment would run about 75 to 100 people.

Senator MELCHER. Seventy-five to one hundred people?

Ms. TRUSLER. Total; carpenters, laborers, plumbers, and whatever.

Senator MELCHER. So, in the ratio of journeymen to laborers, is it 2 to 1?

Ms. TRUSLER. Three. And from our project that we have up there now, we know that these people, up at Browning, that there are Indian people there who are qualified and capable to work on the project.

Senator MELCHER. Well, yes. You would not have any difficulty finding that many laborers, and you would find carpenters and electricians, would you not, that are Indian?

25-642 0 - 83 - 11

Ms. TRUSLER. Well, we have found plenty of Indian carpenters and electricians through the State.

Senator MELCHER. Also plumbers?

Ms. TRUSLER. Plumbers, too. And those people are going to be passed over if Indian preference does not get a little more attention.

Senator MELCHER. Yes; because in a general minority hiring the percentage is a lot less.

Ms. TRUSLER. Right.

Senator MELCHER. Thank you very much, Suzanne. We will take this up with the committee and get some answers on this question.

Ms. TRUSLER. Thank you.

[Material submitted by Ms. Trusler follows. Testimony resumes on p. 175.]

MORNING STAR ENTERPRISES, INC.
GENERAL CONTRACTORS
BOX 328
LAME DEER, MONTANA 59043
TELEPHONE 477-6268
STATE CONTRACTORS LIC. #31644

PROJECTS IN PROGRESS

Job #	Name of Project	Amount
.34	Missoula Sewage Plant Missoula, MT	$ 351,942.00
.36	Rising Sun Wastewater Collection Facility Glacier National Park	$1,387,535.00
.39	Helena Bridges Helena, MT	$ 386,000.00
.42	Alter/Repair Launch Control Facilities Malmstrom AFB, MT	$3,100,000.00

MORNING STAR ENTERPRISES, INC.
GENERAL CONTRACTORS
BOX 328
LAME DEER, MONTANA 59043
TELEPHONE 477-6268
STATE CONTRACTORS LIC. #31948

The following is a list of projects completed by Morning Star Enterprises, Inc. All projects were completed on or before scheduled deadline. There were no defaults or incompletions; and construction quality was excellent.

PAST PROJECTS:

Job #	Name of Project	Amount
.01	Northern Cheyenne Rehabilitation of Homes H.U.D.	$ 300,000.00
.02	Northern Cheyenne Timber Thinning Northern Cheyenne Reservation	$ 350,000.00
.03	Lame Deer Clinic Indian Health Service	$1,230,487.00
.04	Lame Deer Water and Sewer Lame Deer, MT	$ 55,000.00
.05	Radar Facilities - Logan International Airport National Weather Service, Billings, MT	$ 99,000.00
.06	National Weather Service - New Office Bldg. Great Falls International Airport	$ 86,000.00
.07	Central Community Facility - Senior Citizens Center, City of Billings	$ 376,045.00
.08	Administration Building Community Service Facilities, Crow Agency, MT	$ 174,286.00
.09	Sun Lodge Improvements Crow Agency, MT	$ 307,000.00
.10	Glasgow Water Improvements and Storage Tanks Glasgow, MT	$ 99,600.00

Job #	Name of Project	Amount
.11	Water Treatment Plant Crow Agency, MT	$ 66,000.00
.12	Veterans Administration Hospital Fort Harrison - Helena, MT	$ 670,056.00
.13	Wastewater Disposal Crow Agency, MT	$ 176,266.00
.14	Glasgow Standby Power Building Glasgow, MT	$ 30,302.00
.15	Fort Smith Fire Station Fort Smith, MT	$ 126,990.00
.16	Eastside Canal Townsend, MT	$ 155,000.00
.17	FAA Garage Sheridan, WY	$ 30,955.00
.18	Retrofit to Public Works Building Billings, MT	$ 305,060.00
.19	Water Systems Convers - Custer Battlefield Crow Agency, MT	$ 247,338.00
.21	Lame Deer School Lame Deer, MT	$ 44,971.00
.22	V.A. Medical Center - Sanitary Sewer Fort Harrison, MT	$ 26,075.00
.23	Tribal Gymnasium Lame Deer, MT	$ 35,600.00
.24	Domestic Water System - Tower Junction and Tower Falls, Yellowstone National Park	$1,600,000.00
.25	ARS System - Great Falls International Airport, Great Falls, MT	$ 382,000.00
.26	Firestation Remodel Fort Harrison, MT	$ 61,000.00
.27	OR Suite & Intensive Care Unit V.A. Hospital, Miles City, MT	$ 63,108.00
.28	District Watehouse & Office Building Northern Border, Glasgow, MT	$ 210,123.00

Job #	Name of Project	Amount
.29	52 Low Rent Housing Units Fort Peck Indian Reservation	$2,907,000.00
.31	Septic Tanks and Drainfields Indian Health Service, Lame Deer, MT	$ 47,070.00
.32	Remodel Building #2 (FI&R) Crow Agency, MT	$ 345,830.00
.33	J.C.A.H. Fire and Smoke Dificiencies Miles City V.A. Hospital, Miles City, MT	$ 34,000.00
.35	Aircraft Organizational Maintenance Shop Minot AFB, ND	$1,292,349.00
.37	Busby Lagoon Expansion Northern Cheyenne Reservation	$ 63,144.00
.38	Two - 8 Person Crew Quarters Fort Howes, MT	$ 168,000.00
.41	Arco Bridges Busby, MT	$ 26,000.00
.71	St. Peters Hospital Helena, MT	$ 578,730.00
.72	Build Spill Way for Overrun Gibson Dam, - Augusta, MT	$1,800,000.00

July 6, 1983

Indian Preference (42 Federal Regulations 59642), a regulation adopted by the H. H. S. on November 18, 1977, specifying that the Indian Health Services shall follow the requirements of the Buy Indian Act (25 U. S. C. 47).

Under this authority, the I H. S. is required to give preference to Indian contractors in the construction of any hospital or health facility.

An Indian contractor is one which is owned 100% by an Indian - an Indian being a person who is a member of a tribe recognized by the Secretary of the Interior. Morning Star is 100% owned by Suzanne Trusler, a member of the Northern Cheyenne Tribe.

The I. H. S. regulation specifically allows for an Indian firm to enter into joint venture agreements with other entities. Morning Star as an active progressive General Contractor working on a Multi - staff level aligned itself with another Montana Contractor to pursue larger projects as is done by all growing contracting entities. Even without such alignment, Morning Star has the in-house capacity to perform projects such as the Browning Hospital and has amply demonstrated so.

With the joint venture, Morning Star and Bruce Anderson Company easily have the combined resources to undertake the Browning Hospital and a bonding capacity considerably in excess of the requirements of this job, such bonding capacity being 7 Million for Morning - Star and 60 Million for Bruce Anderson Company.

In the joint venture, Morning Star is the majority partner and has the primary responsibility for the performance of the work, including the hiring of the workmen on the job. Morning Star has maintained 75% - or more - Indian employment on its Reservation jobs over the last ten years.

The I. H. S. Regulation also requires that the Indian firm be qualified but no substantive requirements or guidelines are set forth.

We believe that these requirements should be strengthened to insure that the joint ventures are not "shams" or "fronts". Rather, the requirements should insure that Indian firms in Joint Ventures are qualified and Indian-controlled and benefit accordingly, as it would be in our proposed joint venture for the Browning Hospital.

Morning Star, however, is fully qualified under the specific and detailed requirements for Indian firms established by the B.I.A., H.U.D., and the S.B.A.

We must report, however, that there has been, notwithstanding, statements by the I. H. S. to the contrary, a total failure of the I. H. S. to comply with the Indian Preference requirements of the H. H. S.

Communications Between Morning Star Enterprises and IHS/ROFEC Concerning Browning Hospital

November 1980	Tom Trusler writes to ROFEC to express interest in building hospital (cannot locate copy of letter at this time)
November 24, 1980	Suzanne Trusler talks to Emory Johnson, Director of IHS about MSEI's interest in building Browning Hospital
December 9, 1980	Letter to Jim Kennedy from Tom Trusler describing MSEI's interest in and capability in building Browning Hospital
December 1980	MSEI officials meet in Browning with Jim Kennedy
December 4, 1980	HEW acknowledged MSEI's interest in Browning in a memo from Billings IHS to Denver Region of IHS
December 15, 1980	Memo (handwritten) to Jim Kennedy, Browning
December 31, 1980	McIntire of ROFEC writes Tom Trusler to acknowledge MSEI's interest in the Browning Hospital and to say that ROFEC is not responsible
January 29, 1981	McIntire writes Commerce Business Daily Announcement requiring an Indian Preference for the prime contract to design the Browning Hospital
April 20, 1981	Suzanne Trusler called Jerry Weller (ROFEC, Denver) to inquire about status of Browning Hospital construction. Weller replied that Congress would likely cut it from the budget.

May	1981(?)	Tom Moore called Suzanne Trusler to say that the Browning Hospital would be let for open bid without an Indian preference
May	1981(?)	Tom Moore called Suzanne Trusler to say that the funding for the Browning Hospital was cancelled and to forget it
Summer	1982(?)	Congress approves funds for the Browning Hospital
May	1983	Internal ROFEC memo stating that no qualified Indian contractors exist who could build the Browning Hospital
June 10, 1983		ROFEC announces in Commerce Business Daily a non-preference request for competitive bids to build the Browning Hospital

January 29, 1981

Refer to: ROFEC

Commerce Business Daily
U. S. Department of Commerce
Room 1304
433 West Van Buren Street
Chicago, Illinois 60607

TRANSMITTAL NUMBER 05

DEPARTMENT OF HEALTH AND HUMAN SERVICES, REgional Operations
Facilities Engineering and Construction, Region VIII, Room 1194,
Federal Office Building, 1961 Stout Street, Denver, Colorado 80294

R — DESIGN FOR A 27 BED HOSPITAL AND CLINIC AT BROWNING, MONTANA. The project consists of a 27 bed hospital and out-patient clinic. Services of the Architect-Engineer will include project design, preparation of construction documents and construction surveillance.. Design is scheduled to be completed between April 1981 and March 1982. The estimated construction cost is $8 to $10 million. The services advertised for in this aBBouncement will be limited to 100% Indian owned and controlled firms as defined by Buy Indian 25 U.S.C. 47. Selection will be based on the following evaluation factors in descending order of importance. (1) Demonstration of recent experience in design of major hospitals and clinics. (2) Demonstration of abilities required in planning, execution, and control of multi-million dollar projects within house capability or as a joint venture. (3) Professional capacity and demonstrated record for accomplishment of design of this magnitude within a 12-14 month time period.

(4) Experience of personnel proposed for assignment. (5) Qualifications of personnel proposed for assignment. (60 Demonstration of consideration relative to energy efficient designs active and passive. (7) Geographical location of firm, partners, and consultants to project site. (8) Geographical location of firm, partners and consultants to Denver, Colorado. (9) Familiarity with design relative to project site conditions, such as climate. (10) Familiarity with design design of facilities in remote locations. (11) Sensitivity to customs of the Indian nation particularly Blackfeet. (12) Past experience with respect to Government contracts. (13) Interest of firm's owners in project and expected participation and contributions of top officials. 25 U.S.C. 504e(b) requires that Indian or 51% Indian owned economic enterprise as defined by 25 U.S.C. Sec. 1452(3) shall, to the greatest extent feasible, be given preference in any subcontract or consulting contract made in connection with this contract. Firms desiring consideration shall submit SF-254 and SF-255 and other appropriate data within 30 calendar days of date of this publication.

E. W. McIntire, R. A.

Contracting Officer

JEWELLER:gs 1/29/81

12/15/60

JIM,

ATTACHED ARE 15 COPIES OF OUR BROCHERES FOR YOUR USE. WE APPRECIATE YOUR TAKING THE TIME WITH US TO DISCUSS THE HOSPITAL PROJECT.

JIM, IF YOU OR ANY MEMBERS OF THE COUNCIL WOULD LIKE TO SEE SOME OF THE PROJECTS WE HAVE UNDER CONSTRUCTION, JUST LET ME KNOW & I'LL MAKE THE ARRANGEMENTS. I DOUBT IF WE CAN GET THE COMPANY JET INTO CUT BANK, SO WE'LL PROBABLY HAVE TO WORK IT OUT OF GREAT FALLS. ALL I NEED TO KNOW IS HOW MANY AND WHEN YOU'RE AVAILABLE, WITH SOME ADVANCE NOTICE.

THANKS AGAIN,

Larry

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION VIII
FEDERAL OFFICE BUILDING
1961 STOUT STREET
DENVER COLORADO 80294

RECEIVED JAN 5 1981

December 31, 1980

OFFICE OF THE
PRINCIPAL REGIONAL OFFICIAL

Re: Proposed Hospital, Browning, Montana

Mr. Tom W. Trusler
President
Morning Star Enterprises, Inc.
Box 328
Lame Deer, Montana 59043

Dear Mr. Trusler:

Your request for consideration for the design phase of the subject project has been referred to this office by J. R. Smith, Area Director, Billings Area Office, IHS.

As of this date the subject project has not been assigned to this office and we are therefore not in a position to discuss it.

At such time as we formally receive details on this project, we will be in a position to give you more information.

We thank you for your interest and we will keep you posted.

Sincerely yours,

E. W. McIntire
Acting Director, ROFEC

cc: J. R. Smith, Dir
Billings Area Office

MORNING STAR ENTERPRISES, INC.

GENERAL CONTRACTORS

[redacted]

BOX 326
LAME DEER, MONTANA 59043
TELEPHONE 477-6266

December 9, 1980

Mr. Jim Kennedy
Tribal Health Director

Dear Mr. Kennedy:

Morning Star Enterprises has joined forces with Morrison-Knudsen Co., Inc. so that we can specifically address the challenge of the forthcoming Hospital Construction Program in Browning, Montana. We feel that the Tribe cannot realize the full economic and social benefits of this program unless the following concerns are addressed early in the planning phase:

1. Training. Our firms have extensive experience in the development of programs to train under-achieved people in a variety of skills, ranging from all levels of construction to those involved in clerical and administrative activities. Native American Indians have been trained in the construction of railroads, dams, power plants, pipelines, missle sites, hospitals, and other types of work. These programs have been aimed toward providing Native Americans with work habits and skills which lead to permanent employment.

2. Value. Our management and construction experience can enable the Tribe to realize the most benefit from the funds expended. On a recent hospital constructed for the Norton Sound Health System in Nome, Alaska, savings accrued during construction in the amount of approximately $600,000 were used to provide additional construction; thereby utilizing the entire appropriation of funds for the Tribe's ultimate benefit.

3. Time. In an industry where "delay" has become a by-word, our firms have developed an impressive record of completing projects ahead of schedule. Although we can't control the lengthy process of obtaining funds, we can insure delivery of the facility in the least amount of time, once funding is available.

With the above introductory, we appreciate the opportunity to meet with you and discuss how we can structure our services to satisfy your requirements.

Very truly yours,

Tom W. Trusler
President

TWT:mp

MORRISON-KNUDSEN COMPANY, INC.

INTER-OFFICE CORRESPONDENCE

DATE: December 8, 1980

TO: R. J. Harvey

FROM: L. Keys

LOCATION: Buildings Group
B.H.O.

LOCATION: C-2926
Helena, Montana

SUBJECT:

Meeting - Browning Hospital
Tuesday, November 25, 1980

Tom and Suzanne Trusler and myself met with Jim Smith who is the Billings Area Director of the Indian Health Service.

The hospital in Browning can be constructed with funds provided to the Tribe if the Tribe requests a grant to do so. A meeting has been arranged with the Tribe to discuss the grant on December 9, 1980. Tom, Suzanne and I will meet with the Tribe then.

LK:mp

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

TO : Principal Regional Official, DHHS Region VIII
Denver, Colorado
Attention: Director, ROFEC

DATE: DEC 4 1980

Refer to: EHE/AFM

FROM : Director, Billings Area
Indian Health Service

SUBJECT: Browning Hospital Project - Morning Star Enterprises, Incorporated/Morrison-Knudsen Company, Incorporated Interest

The above companies have expressed interest in building the proposed hospital at Browning, Montana.

A letter from Mr. Tom W. Trusler, President of Morning Star Enterprises, Incorporated and resumes are attached for your information.

Please inform these companies how they can be considered for construction projects by your office.

J. R. Smith

cc: Mr. Tom W. Trusler, President, Morning Star Enterprises Incorporated, Lame Deer, Montana

Attachments

PROJECTS LET BY REGIONAL OFFICE OF FACILITIES ENGINEERING CONSTRUCTION (ROFEC), DENVER, PER JERRY WELLER -- 7/6/83

1.	10 Units of Housing Lodge Grass, MT	$1,060,000	Indian Preference
2.	Browning Hospital (Design Only) Page-Werner, Architects	$ 600,000	Indian Preference
3.	Roofing Browning, MT	$ 150,000	Not Indian Preference
4.	Rennovation of Clinic Browning, MT	$ 200,000	Indian Preference
5.	Repair Roofing Crow Agency, MT	$ 40,000	Not Indian Preference
6.	Repair & Painting Quarters Lame Deer, MT	$ 20,000	Indian Preference
7.	Remodelling X-Ray and Air Conditioning System Browning, MT	$ 50,000	8A - SBA
8.	Painting Quarters Browning, MT	$ 4,000	Indian Preference
9.	Replacing Furnaces Crow Indian Reservation	$ 22,000	Small Business Set-Aside
10.	Repairing Retaining Walls Rocky Boy Indian Reservation	$ 18,000	8A
11.	Installing Voltage Regulators Ft. Belknap Indian Reservation		Not Indian Preference

Senator MELCHER. We are at the point now where we want to hear from the Indian Health Service. Is Jon Hauxwell here? Jon, and James Danielson, and Dr. Copp?

Please proceed, Jim.

STATEMENT OF JAMES DANIELSON, DIRECTOR, BILLINGS AREA INDIAN HEALTH SERVICE, ACCOMPANIED BY DR. DANA COPP, ASSISTANT AREA DIRECTOR FOR PATIENT CARE, AND DR. JON HAUXWELL, CLINICAL DIRECTOR, LAME DEER SERVICE CLINIC

Mr. DANIELSON. I am James Danielson, director of the Billings area Indian Health Service. I am accompanied by Dr. Copp on my left, assistant area director for patient care; and Dr. Jon Hauxwell, clinical director from the Lame Deer Service Clinic.

I wish to offer Dr. Rhoades' apologies for not being able to be with us today. And I have offered up the opening statement that, for the record, Dr. Rhoades would have introduced had he been here.

And rather than proceed with any opening statement, with your indulgence, I would like for us to be able to respond to questions you may have at this time.

Senator MELCHER. Fine. We will make Dr. Rhoades' statement a part of the record at this point.

[The statement follows:]

PREPARED STATEMENT OF DR. EVERETT RHOADES, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee, I am Dr. Everett R. Rhoades, Director of the Indian Health Service (IHS). With me are Mr. James Danielson, Director of the Billings Area Office, Dr. Dana B. Copp, Assistant Area Director for Patient Care, and Dr. Jon Hauxwell of the Northern Cheyenne Service Unit. I am pleased to be here today in Montana. Mr. Danielson will be glad to discuss with you and your Committee any questions about the operation of the health care program by IHS in the local area and I will be glad to discuss with you any overall policy questions.

As you know, the IHS represents the primary Federal health commitment to approximately 900,000 eligible American Indians and Alaska Natives living on or near Federal Indian reservations and in traditional Indian Country. The IHS carries out this mission through a comprehensive health delivery system providing high quality preventive, curative, rehabilitative, and environmental health services. It does this through programs managed and operated by both the IHS and various tribes utilizing both direct and contract health services. In addition, limited health services are provided in 37 urban locations having an Indian population of about 300,000—half of whom are included in the 900,000 figure. Seven of these projects are in Montana.

The total estimated IHS service population for the Billings Area is 38,859 for FY 83 and 39,993 for FY 84.

To date the FY 83 appropriation to the IHS for health services totals $658,183,000.00. The Billings Area's share of the FY 1983 appropriation is $43,684,900.00.

The IHS is constantly endeavoring to provide quality health care to Indian people while recognizing that the medical needs of Indian people demand a special measure of priority and attention from the Federal Government.

In 1976, in the Indian Health Care Improvement Act, the Congress defined the scope of the IHS program and established a national goal of providing the highest possible health status to Indian people while encouraging maximum Indian participation in health programs.

In your letter of invitation you stated that you wished to discuss the need to reauthorize the Indian Health Care Improvement Act, P.L. 94-437. As you

know, section 701 requires the Secretary to submit to Congress a final report on P.L. 94-437 including an assessment and recommendations. That process has only recently been initiated so I cannot at this time report on any Departmental decisions.

Mr. Chairman, that concludes my opening remarks. At this time we will be happy to answer any questions you may have.

Senator MELCHER. What is the reasoning, as far as you know, behind IHS billing the county as if the Indian patient were on welfare rolls?

Mr. DANIELSON. The process that we have been advised to follow is that IHS would proceed, at all locations to the maximum ability, to collect the benefits that an individual would encounter, being a citizen, and prior to us utilizing our resources to cover costs of care, which is maximizing third-party involvement.

Senator MELCHER. Well, why would you not do that with every patient then?

Mr. DANIELSON. We are doing that.

Senator MELCHER. With every patient?

Mr. DANIELSON. Yes. It has nothing to do with the resource itself, it has to do with pursuing all resources for all patients.

Senator MELCHER. So, therefore, the Federal policy should be that the health care needs of the Indian people should be met by the county?

Mr. DANIELSON. The policy, as we are instructed to implement it, is to attempt to utilize other resources to the degree we can in order to maximize the efforts which have been put forth with what we have.

Senator MELCHER. What regulation was used to back that up?

Mr. DANIELSON. The regulations—I cannot cite for you the actual location—but it is in the contract health portion of our manual.

Senator MELCHER. How long have you worked for IHS?

Mr. DANIELSON. For almost 20 years.

Senator MELCHER. Is this the first time you have followed this policy?

Mr. DANIELSON. No, sir.

Senator MELCHER. Where were you successful in following the policy before?

Mr. DANIELSON. IHS has always had processes in place whereby they attempted to utilize all the resources that were available, from whatever source, in order to maximize the dollars we had, as well as provide some service to the individual patients that IHS——

Senator MELCHER. I am only asking when were you successful in getting the county to pay for health care needs of an Indian patient if they were welfare recipients?

Mr. DANIELSON. I have not been successful in that particular kind of endeavor.

Senator MELCHER. You have never been able to use it?

Mr. DANIELSON. True.

Senator MELCHER. Why should you be able to use it now?

Mr. DANIELSON. It happens to be an issue here simply as a part of the larger overall process.

Senator MELCHER. What is the larger overall process?

Mr. DANIELSON. That would be the contacting of all of the various organizations and agencies that provide services so that we might be able to get them to assist in providing care.

Senator MELCHER. Well, I think you are forced to give the most illogical answer to these questions. You are told to do this by a letter or something?

Mr. DANIELSON. No, sir, I am told to attempt to explain what the policy is that we are attempting to implement.

Senator MELCHER. That is what I am asking. Then you were told to implement it by letter directive, memorandum, or what? It should not be any secret.

Mr. DANIELSON. No, sir. It was done through the discussions in terms of maximizing our resources.

Senator MELCHER. In other words, there is no memorandum, letter, or anything of that nature, that is in writing?

Mr. DANIELSON. There is not a letter that emphasizes that we should go back and specifically pick that piece out and begin to work with that, no.

Senator MELCHER. Well, then, were there rather explicit oral discussions on it?

Mr. DANIELSON. Yes.

Senator MELCHER. And when did those discussions take place?

Mr. DANIELSON. The latest discussion that took place, took place during the area director meeting in Albuquerque, N. Mex., in about the middle of spring.

Senator MELCHER. Like in April?

Mr. DANIELSON. Yes.

Senator MELCHER. And who gave you that instruction?

Mr. DANIELSON. It was a discussion with the director of Indian Health Service.

Senator MELCHER. Dr. Rhoades?

Mr. DANIELSON. If I could, sir, the instructions that we received were to attempt to utilize all resources that were available to an individual patient, along with the resources that we have available to provide care.

Senator MELCHER. Does not this oral discussion in Albuquerque, between Dr. Rhoades and the area directors, take on all the attributes of a change in Federal policy?

Mr. DANIELSON. No, sir. We interpret it as being a reemphasis of what was already in existence and was being carried out.

Senator MELCHER. You have been with Indian Health Service for 20 years, and you say you have been trying to tap all these resources, yet you never tapped anything from the county?

Mr. DANIELSON. I said I am not aware of anything specifically involved with things in the county; no.

Senator MELCHER. Pardon me?

Mr. DANIELSON. I have not been personally involved with any resources coming from the county; no.

Senator MELCHER. Well, why not? Why not try, in 20 years, if you thought it was a requirement?

Mr. DANIELSON. The assignments that I have had to date have not specifically dealt with working with special emphasis on the details of case findings of that degree.

Senator MELCHER. The what?

Mr. DANIELSON. My assignments have not called for me to be actively involved in that kind of case workup until I arrived out here.

Senator MELCHER. As an area director?

Mr. DANIELSON. That is right.

Senator MELCHER. That is the highest office you have held in Indian Health Service?

Mr. DANIELSON. No.

Senator MELCHER. You are at a lower level now as area director?

Mr. DANIELSON. Yes, sir, I am at a different level.

Senator MELCHER. A lower level?

Mr. DANIELSON. Yes, sir.

Senator MELCHER. Well, the Federal policy has been that there is a trust responsibility for Indian health by the Federal Government, and this policy would put the first responsibility on the county.

Mr. DANIELSON. This policy places responsibility for Indian Health Service to attempt to provide care with a maximum utilization of all resources, the mixing of resources.

Senator MELCHER. We have gone over that. We are right to the point of where you applied this was at the county level. You have not gone after an insurance company.

Mr. DANIELSON. Yes; we have.

Senator MELCHER. Successfully?

Mr. DANIELSON. Yes.

Senator MELCHER. Well, why then do we receive this testimony today that the Indian employees on the Browning school system who carry insurance provided for by the school board are going to IHS and their bills are not being paid by the insurance company?

Mr. DANIELSON. I think as a general statement, that is true, that IHS does not have a standard method of providing that kind of billing. But, there are cases of where, when those resources are known, that they have been pursued and IHS has been successful in getting part of the payment for services covered by that source.

Senator MELCHER. Well, there is no question but what an insurance company that gets a premium payment every month from the school board for a schoolteacher has some obligation to pay for the health care costs of that individual up to the extent of the terms of the policy. But, IHS does not collect that.

Mr. DANIELSON. Correct.

Senator MELCHER. So IHS is going to pursue a rather flamboyant policy of billing counties under Montana law. Under Montana law you are not obligated at all, up until now, to my knowledge, which may be incomplete—you may be demonstrating that—are not obligated under Federal law.

Mr. DANIELSON. I think the reason that issue is receiving so much attention right now is that there are distinctly two different sets of opinions about the process and their relationship to each other.

Senator MELCHER. Well, I think Dr. Rhoades has instilled in you again the idea that you are supposed to collect it from the county. If he installed that idea with you in this oral discussion with you in Albuquerque——

Mr. DANIELSON. No.

Senator MELCHER. Well, let me complete my statement. If that is his attitude, he is going to have a rough time in Washington. He is just doing his job, and that is not my understanding of what he is all about and why he wanted this job of being Director of IHS. I do not believe

that is the policy of the Federal Government. I do not believe it is Federal law, and furthermore, if it were the case, I think we would have a very active committee clarifying the Federal law for Dr. Rhoades and for all of you in IHS. I do not believe that is the case anyway.

How many other counties besides Hill County have you billed?

Mr. DANIELSON. I think there are, actively involved in the process, probably four or five others.

Senator MELCHER. Four or five others?

Mr. DANIELSON. Yes.

Senator MELCHER. Rosebud County?

Mr. DANIELSON. Yes.

Senator MELCHER. Big Horn County?

Mr. DANIELSON. I think probably so; yes.

Senator MELCHER. Wherever there is a reservation, there is a bill to the county?

Mr. DANIELSON. That is an issue in each one of those locations, yes.

Senator MELCHER. Are you paying the hospitals and then asking them to collect from the county and then they in turn pay back IHS?

Mr. DANIELSON. Well, sir, the process that we have been using, that we have used in most cases is that IHS has identified those places where there are all those other resources, and they then use the local system for identifying whether or not there is a proper responsibility for that particular agency to pick up those costs.

Senator MELCHER. Well, I think I have dwelled on this long enough. Let me turn to another point.

Would you recommend that under existing statutes, that transfer directly from medicaid funds and medicare funds on the Federal level be made to IHS for those patients that are eligible for those two programs?

Mr. DANIELSON. It would certainly facilitate the management of those resources to do that.

Senator MELCHER. Is it the understanding at your level that the law is not clear enough on this? Our intent was clear to us—I will say that—clear to Congress. To you maybe the law is not clear.

Mr. DANIELSON. It seems that a part of the process has to do with internal administrative operations, as to variances, as to what the law says.

Senator MELCHER. Do you know where those problems are? Are they with the medicare/medicaid people, or are they with IHS people?

Mr. DANIELSON. Health Care Finance Administration, I think, has a different understanding about the whole process.

Senator MELCHER. Is that where the problem is? Do they have a different understanding of that statute's intent?

Mr. DANIELSON. Yes.

Senator MELCHER. Thank you. We will pursue that with them. It seemed to us the intent was clear, and we thought the language was clear, but maybe it is not.

Senator MELCHER. We recognize the difficulty of the accreditation of the facilities. And we wanted this money collected from medicaid and medicare to be earmarked to go directly to accrediting facilities, and we do not think it is being used, not only in the transfer like we thought it should be, but we do not think it is being used for that purpose either.

We thought that was the most pressing need we had at the time, so it is kind of slipping by the board. And we will take it up with them.

But the intent, as far as you know, of what Congress had in mind in that regard is misunderstood by IHS, the HCFA, and the finance level.

Mr. DANIELSON. Yes. In discussions that I have had on the subject, that is true.

Senator MELCHER. What is the hangup on the, I think it was $18 million of HUD money for water and sewer improvements that was to be transferred directly to IHS to be available for use by IHS? Do you know?

Mr. DANIELSON. Is the discussion having to do with the jobs bill money project?

Senator MELCHER. No; it is older than that.

Mr. DANIELSON. No; I am not aware of——

Senator MELCHER. You are short of water and sewer money, are you not?

Mr. DANIELSON. Yes; we are.

Senator MELCHER. Virtually out?

Mr. DANIELSON. That is correct.

Senator MELCHER. We are at a loss to explain that since congressional action was taken to make the funds available to HUD in that amount—approximately $18 million to be made available and transferred to IHS for water and sewer.

Mr. DANIELSON. No; that is at the national level, and I am not aware of the details of it.

Senator MELCHER. We will pursue that for you, too. We have a copy of this request for competitive bidding affecting the Arapahoe and Shoshone. And it says, "Preproposed conference will be held at 9 a.m. on July 19." Now, this conference would take in hospitals, I assume, in other areas other than Lander and Riverton. Is that not true? Is that not what this is designed to do?

Mr. DANIELSON. If I may, I would like for Dr. Copp to respond to that, and maybe if I could take the liberty of expanding a little broader issue after we finish that to talk about some of the——

Senator MELCHER. That will be fine.

Dr. COPP. I am Dr. Copp, the intermediary officer of the area. And with response to that, requests for proposals were sent out to more than those two hospitals in Wyoming. At the same time, however, I am not sure how many of the hospitals are going to send representatives to our preproposal meeting on the 19th there at the reservation. All of them certainly have the opportunity to do so.

Senator MELCHER. Well, yes, everybody could get in on the act. Why do you want this, Dr. Copp? What prompts you to ask for this?

Dr. COPP. Why do I want competitive bidding?

Senator MELCHER. Yes.

Dr. COPP. We have been mandated, apparently, to pursue the process of competitive bidding. That is my understanding of it. I personally feel as though this may not be the best alternative in terms of attempting to conserve the available funds for contract health services for inpatient care. But we are attempting, in the best way possible, to pursue what we have been told has to be done.

Senator MELCHER. Who told you?

Dr. COPP. Well, in my particular circumstance, of course, the area director relays my instructions to me.

Senator MELCHER. This area director?

Dr. COPP. That is correct. But the mandate, I believe, comes to us from Washington. Certainly it is not a local initiative by any means.

Senator MELCHER. You are not doing it in Montana?

Dr. COPP. That is correct.

Senator MELCHER. You are told not to do it in Montana?

Dr. COPP. No; we provided a justification to Rockville at the time the general mandate came down. They said it was going to be far more complex on the reservations in Montana. We requested a delay in implementing it. We were authorized that.

Senator MELCHER. Now, Jim, why do you tell them to do this?

Mr. DANIELSON. We, as you are aware, are still acting under the mandate to pursue it as rapidly as possible. In taking a look at each one of the individual service areas, the Wyoming part of the program is, on the surface, much less complex in terms of the problems we are going to be forced to deal with. And you heard a citing of an awful lot of potential difficulties with going into that effort.

Looking at those, we have worked for quite some time in trying to build into it the amount of latitudes and decisionmaking that will allow us to implement the process. At the same time, the primary consideration being quality health care.

Senator MELCHER. Well, you know, I respect you having to do what you are told to do. But it is this sort of stuff that just literally drives me up a wall. We continually talk about using the funds to get out to the sick patient, and we find you have to follow these kinds of procedures.

I do not suspect that the circumstances down there for the Shoshone and Arapahoe are any less complicated than they are right here in Montana. I recognize that when you send out a document like this, you send up all the forms with it. You cannot help but spend several thousands of dollars doing it. I don't think this document got out without spending a couple thousand dollars. If it would lead to anything, I guess it would be all right.

But as it was described here today by that joint health corps, it is not going to lead to anything but a competitive situation between a number of hospitals that, if you pursue it, is offered at a lesser price. It probably would mean that these patients would be driving a lot greater distance to get good health care.

Now, I am going to ask Dr. Rhoades to cease doing this, to reverse the mandate immediately and go for a different approach.

First of all, if a hospital is charging a non-Indian patient the same as it charges an Indian patient, it seems to me that that is a test; the only test of whether or not the hospital is a good hospital.

Now, is there anything wrong with that feeling? That is a traditional feeling, I think, of IHS, and everybody else in the health field.

Mr. DANIELSON. No; I certainly think that the points that were made this morning were made accurately, and would portray the perspective that the Billings area in Indian Health Service has.

Senator MELCHER. Well, the term was used PPO, which is—Doctor, what does that mean?

Dr. COPP. Preferred provider organization.

Senator MELCHER. And Salish and Kootenai developed a plan which resolved the difficulty there when they joined the hospitals in the Flathead area. Secretary Margaret Heckler found favor with that.

I am going to ask Dr. Rhoades to hold off on this and review the PPO processes, and to ascertain if that is not a better approach.

Dr. COPP. You probably should understand that out there in the Flathead Valley, this PPO plan was developed with the director of the health board.

Senator MELCHER. And with the area office?

Dr. COPP. Yes. We were involved in the process. The problem, of course, that was confronted was that the tribal council did not accept the concept of the PPO, so it was the tribal council that objected, I believe, to the process. At this point, at least, they have not bought off from going with that proposal.

Senator MELCHER. Well, I think the health board is in a better position to make that judgment.

Dr. COPP. Very likely. But that is their governmental and political process. I would like to comment on that, if I may, from the standpoint that PPO is indeed a very appropriate kind of a concept for us to look at and work with.

Senator MELCHER. Well, in effect is it not formalizing what you do anyway?

Dr. COPP. It goes a little beyond formalizing what we are doing. But I even had some discomfort with that process insofar as I do not think it necessarily goes far enough. If indeed we are making the arrangement for contract care with the private sector, which is what the PPO is involved with, it strikes me that we are as an organization on a fixed budget with the requirement to provide services to a fixed population. Under a PPO, like any independent contract arrangements with any individual physicians, there is no control over the utilization of the services.

In essence, we simply are billed and we paid the bills. It is difficult with a fixed budget to try to work that way because we do not know what our expenses are going to wind up to be.

The preferred solution to that is to deal with some sort of a prepay arrangement, to attempt to negotiate with private providers some sort of prepaid arrangements, so that in essence the mess is shifted to the provider group. This provides some additional benefits, also.

Senator MELCHER. I am going to have to think about that, because if you have a prepaid, I also wonder, when they have a greater patient load than they anticipated, whether they are going to try to save some costs themselves.

Dr. COPP. Sure.

Senator MELCHER. In health care, there are a couple of things that are not being utilized, and we know that. First of all, I think, legally medicare and medicaid should be utilized and there should be no hitch in that at all.

But we will go over that with the finance people in the Health and Human Services and find out what their hangup is. They may have looked at it more carefully than we through all various legal con-

straints. Probably there is no adequate directive from Congress requiring it.

But second, Indian patients who are covered by private health insurance—certainly those funds should flow to the extent that they would obligate the insurance company, should flow directly to the Indian Health Service when the service is provided by the Indian Health Service. I think we may have to direct that into the statutory language and include it in one of the bills we have before us.

Dr. COPP. These things would be helpful. It is my understanding at the present time—I may be misguided—but it is my understanding that on routine billing of insurance companies that we are not authorized to do that at the present time, where the individual has personal individual health insurance. We do pursue the reimbursement on the litigation cases. Like an auto accident, we pursue those third-party cases.

But, I do not believe we are authorized at the present time to pursue individual health insurance policy reimbursement on our services.

Senator MELCHER. If you are not authorized to do that under existing statute, I think all commonsense would tell us to put that into the statute, because it is definitely a debt.

Dr. COPP. Yes; I believe that is being pursued at headquarters.

Senator MELCHER. We will attempt to do that in this particular bill because it is a bill before us—or there will be shortly a bill before us, and we want to get it passed this year. So it will be one of the features in that. We will be consulting with legal counsel there and properly draft it.

On the question of running out of funds: I think to be fair about it with everybody, I think there is a great deal of merit to what former director Emery Johnson said, when he told the committee formally in February—that is fairly recent—that was sort of his last swan song. Dr. Johnson had several swan songs before he finally retired. But his last advice to the committee, I think, was to correct the situation where you had to consult the bureaucratic levels above Indian Health Service constantly. They change with every administration, naturally, and sometimes in between. Spending 85 percent of your time is just terribly burdensome and time consuming, and takes away a lot of the real action of the whole service.

I think Dr. Johnson wanted to retire a year and a half before he actually retired, but he did not want to leave the Indian Health Service without a new Director in place.

He was concerned that the position might be filled by somebody who was totally unfamiliar with what Indian Health Service is for and what its traditional duties are. So he stayed on.

But he also testified at that same time that proposed Indian Health Service actions had to clear 38 desks before any final action could be taken. That is a terrible amount of bureaucracy, and it is a terrible cost involved. And it certainly takes away from actually doing the work that Indian Health Service wants to do. So there is a real merit in elevating that job to assistant secretary.

We have some other questions we are going to have to clear up with you.

As we stated earlier, we will try to make part of this bill simplify the chain of command for Indian Health Service and put it on a level

where the assistant secretary of Indian Health Service can have equal access, along with all the rest of those assistant secretaries, to the secretary of HHS.

We have to go into this question on the clinic at Wolf Point. Now, you heard the testimony of the director of the Trinity Hospital up there. I know this upgrading of that clinic at Wolf Point for Indian Health Service has been a consideration for many years. I think that you have all signed off on it and felt that there was an urgent need for it; is that correct?

Dr. COPP. Yes. The information that that is based upon is 2 years old. The process now is that once the House report comes out, we will be asked to effect a statement as to any changes and any effect on the program that that brings about. And at that time we will get with the tribe in updating the information that we presented with the original project.

Senator MELCHER. Can we alleviate that problem where there is an emergency, where an Indian patient is presented to a private doctor, and that doctor determines that the emergency is there and needs to be handled forthwith, and then finds that the bill is turned down? I hate to hear that. I know it happens. And I would just like to think that it will never happen again, because the judgment of a doctor on what an emergency is has to be accepted.

Dr. COPP. Well, that is a problem we face in adopting the emergency standard for contract services. This, again, has been imposed on us as a necessary mechanism of dealing with the type of budget that we live with today.

We are willing to accept that responsibility. But when you introduce that kind of a standard, then you invariably deal with the variation between the lay person's perception of an emergency and the physician's perception of an emergency.

Senator MELCHER. Now, wait a minute, though, who is the lay-person?

Dr. COPP. The patient.

Senator MELCHER. The patient goes to the doctor, and it is an Indian patient, and he says, "Doctor, I want you to take care of me." The doctor makes an examination and decides that treatment is necessary. At that point, it seems to me the judgment has been made and all you can do is accept the bill.

Dr. COPP. There is a difference between some treatment which is necessary and what is regarded in our priority system now as emergency care that must be administered through a private hospital, a private physician, under contract services, as opposed to those that we can provide directly through our own facilities.

That is where we get into the conflict. Because, indeed, when those services are provided and are clearly not emergent in nature, a referral should have been made to the IHS facility's physicians.

Frequently that does not happen, for whatever reason. And when that happens, then we fall into the position of making some kind of a judgment call, on whether we should be reimbursed for that or not.

It would be nice to adopt a fairly liberal approach and accept the fact that if that private physician said that the services—or believed that the services were necessary to perform at that time, that we could automatically accept that and indicate it on the bill. However, if we do

that, there would be no way for us to begin living within the limited contract service budget that we have.

Mr. DANIELSON. Senator, Dr. Hauxwell, as a practitioner, says he would like to make a comment to this.

Dr. HAUXWELL. I wish that every doctor's determination as to an emergent status of a problem was based strictly on medical considerations. Unfortunately, that is not always true.

We have found it necessary at our unit to look through the retrospectroscope and evaluate charges that we are presented with. By way of a few examples, we were billed for treatment of an ingrown toenail as an emergency. And, when we investigated, it was quite clear that nothing about the case indicated in any way that it was emergent.

The layman's perception of emergency is important because if a person presents himself to an emergency room—someone came to my emergency room last night with a case of poison ivy that they had had for a week. It was not any worse, it was not any better. They finally decided about 11 o'clock that they ought to do something about it. In their perception it was worth a visit to the emergency room.

Had they gone to a private emergency room and the doctor looked at them and said, "I agree this needs to be treated, but you have obviously not considered it an emergency yourself over the past week. You have had numerous occasions to go to the clinic." Already the bill is established. Just for going to the emergency room. Before the doctor even knows if it is an emergency or not.

The patient who elects to obligate us for a nonemergent problem regardless of what determination the doctor makes, necessitates our looking at this retroactively and making some determination, because otherwise there is a tendency on the part of the patient, and on the part of some doctors unfortunately, to simply go ahead and treat nonemergent cases and bill us for it. We can not afford that.

I have to sit down with a patient and say:

I think that pain you had last week was indeed your gall bladder, and I suppose the best thing to do is to get your gall bladder taken out now that you are feeling pretty good and pretty healthy. But, we can not pay for it. We do not have the money.

Now, that is a reality imposed upon us by our budget. Now, if that same patient can go to a doctor in town and say, "They told me I had a gall bladder attack last week, and the best thing to do is get it taken out," and he goes into the emergency room—although he is feeling all right—if the surgeon has no reason not to just stick him in the hospital and operate and bill us for it, he will do it. And we do not have the money to pay for it.

Senator MELCHER. Well, Doctor, if a doctor bills IHS, and he says that patient approached me on this date and in my judgment he needed treatment immediately, not one of the three of you are going to tell that doctor that he does not know what he is talking about, are you?

Dr. HAUXWELL. I have on occasion done just that.

Senator MELCHER. Face to face?

Dr. HAUXWELL. On the phone. I mean, it may be a number of miles away. If the patient comes and says, I would like to get this treated, but you will not get paid for it unless you call it an emergency, there are doctors out there who will call it an emergency.

I wish it were not true, but it is true.

Senator MELCHER. I know. I am talking about the situation where the doctor insists that it was indeed an emergency. I am not talking about what the patient says at all. The patient arrived there, and the doctor determined that there was an emergency and that he needed treatment then.

Dr. HAUXWELL. And we learn about that when we get the bill. Then we have to decide why did the doctor call it an emergency. And certainly in most cases it is an emergency, and we pay it, if that happens.

There are some cases—and that is why we have to look at all of them—there are some cases in which it is quite clear from the evidence, the information the doctor himself provides, that no emergency existed, and he had other reasons for so designating it.

Senator MELCHER. Let me point out this. In the face-to-face confrontation, there are not that many doctors who are actually treating very many patients on an emergency basis.

Over the course of a few years, all of you know each other quite well. And if the doctor maintains the patient really needed some treatment right then, there would not be much argument after that. It is a question of whether or not you have the money.

What else is new in the practice of medicine? These doctors do not get paid all the time, monthly. If you really think they have it coming, you will see that they get it, even when you are out of funds.

Dr. HAUXWELL. That is true.

Senator MELCHER. We are going to see that you get the funds that you need. I am not talking about those cases where something else could have been worked out. I am talking about the cases where an emergency truly existed and the doctor made that judgment and the patient, if he were not treated, could possibly have lost his life.

That is all I am talking about. And I just hope we do not hear of it anymore. I know we do not want anybody to abuse it.

Doctor, how do you pronounce your name, Hauxwell?

Dr. HAUXWELL. That is right.

Senator MELCHER. Do you know all the doctors in Miles City and Great Falls—or Billings—Forsyth?

Dr. HAUXWELL. Not Billings.

Senator MELCHER. I do not think you will ever know all of them in Billings. But, you know a great number of them. You will be able to work with them and feel comfortable.

Dr. HAUXWELL. That is true. My point is simply that we have to look at all the bills we get for cases that we do not refer out, to make that very distinction, whether it was a bona fide emergency, as the majority are, or whether it, in fact, is not something we should be paying for.

The lady in labor, for example, may need to stay at the first place she shows up and deliver. Or she may be in very early labor, or semi-dilated, and have 14 hours before she delivers. Most doctors can make a reasonable determination at that point, and we have to provide them some incentive to do so.

Senator MELCHER. Well, also, it might have involved some of you people; one case where they discussed the ectopic pregnancy, a decision was made by an IHS doctor there at Wolf Point or Poplar area.

Dr. HAUXWELL. Well, again, I have referred people for evaluation of an ovarian mass which might potentially be an ectopic preg-

nancy. But it was my determination of how to handle it: that is to ship them in an ambulance, call for a helicopter, or simply request contract care and make a special appointment within the next 48 hours.

My decision as to how to handle that, how fast and where, is based on my clinical assessment of the patient; how far along they are, how tender that mass is, that sort of thing. So I cannot say that a suspicion of ectopic pregnancy per se contra-indicates the hour drive.

Senator MELCHER. Well, I think the patient's desire has to be recognized, too. The patient does not really want to go to Williston. And I do not think too many people on the reservation want to go to Williston. They would like to stay right there in Wolf Point.

I do not know much about the facilities at either place. But I think they probably knew what they were talking about in that instance. It could have been handled there at Wolf Point. It possibly should have been.

Well, Doctor, you are right on the firing line of Indian health care for an Indian tribe. Ted Risingsun thinks that alcoholism is the greatest disease over there. He says it is serious. Do you agree?

Dr. HAUXWELL. Absolutely.

Senator MELCHER. Are you making any headway?

Dr. HAUXWELL. Sometimes it is a matter of not seeing the forest for the trees. I think we have made some beneficial changes in the 6 years that I have been there. But I also think that in terms of the end result, the number of people that I see in an emergency room with alcohol-related trauma, the number of target organ diseases of alcoholism, such as liver and skin and stomach and so forth, I would be hard pressed to say there has been much of a dent made in the incidence of those things.

Senator MELCHER. There is no alcohol on the reservation?

Dr. HAUXWELL. It is illegal to sell, possess, consume, or be intoxicated by alcohol on the reservation. There is alcohol all over the reservation.

Senator MELCHER. Not as sold, that is in force?

Dr. HAUXWELL. There is active bootlegging and use of Montana gin. That is, lysol or hairspray is quite active, also.

Senator MELCHER. Is the halfway house, which I understand has only been in operation for what, 6 months, is that promising?

Dr. HAUXWELL. Probaby less than that. Yes; it is very promising. Our choice heretofore has been to primarily keep them there with relatively nonintensive treatment; keep them in the community. When you send them away to a totally artificial environment, when they reenter from that environment, it is like ice water. It is such a terrible shock that a lot of people cannot handle it. So, I think the graduated entry has a lot of merit.

Senator MELCHER. I wonder, if we followed this recommendation of the contract health care task force that the priorities and treatment be set on a national basis, would that take away some flexibility that is absolutely essential?

Dr. HAUXWELL. I would not like to see such a federally centralized determination of what I think is a local issue. As an example, we have a lot of diabetes, but it is rare to nonexistent to see a gestational diabetic. That is a woman whose diabetes only comes out when she is pregnant, and which causes problems to her child during pregnancy.

Yet, in the Southwest, gestational diabetes is a problem. I would hate to see an expensive, large-scale gestational diabetic screening program instituted on the Northern Cheyenne Reservation. But it might be very appropriate in the Southwest.

Senator MELCHER. So we better allow flexibility rather than setting the priorities nationally.

Dr. HAUXWELL. That is my opinion.

Senator MELCHER. If we took these medicare and medicaid funds—for that matter the private health insurance funds—and did the most simple procedure; just had them transferred nationally, at least for medicare and medicaid in Washington, would that hamper what would be available at the local level, or do you think it would work its way down through the entire framework?

Dr. HAUXWELL. You mean a centralized, funded headquarters would receive the money?

Senator MELCHER. Well, the easiest way to collect that money is just have a voucher sent in, or a claim sent in from an IHS hospital or clinic, that this is a medicaid patient; and therefore, the billing to medicaid would go into Washington and transfer would be made directly right there. That would be the easiest way to do it. And the transfer in Washington from the medicaid fund to the IHS fund, how do you think that would work?

Dr. HAUXWELL. If we could bill for services that we have been rendering without reimbursement; now, we are talking about onsite services; my preference, of course, would be to see those moneys returned to the local level fairly quickly so that we could apply them according to our needs.

Perhaps I am paranoid, but I have a feeling that funds that, based on our services which are simply returned to a centralized funded headquarters or something, even if it is not IHS funds, might be dissipated a lot as it trickles down.

Senator MELCHER. Maybe we could earmark it then. We have done that before, where funds collected are paid into the Treasury, we would occasionally earmark them or credit them to the area where the funds were collected. We did it, for instance, in fees paid to the Forest Service, or the BLM. What was available in a local area was collected and we made them just set up an earmarking system. Maybe we could do the same here; collect the money right there in Washington, but earmark it to pay out—whatever you want to call the instrument, where you have actually provided the service, for that money to be credited back.

Dr. HAUXWELL. I would take it wherever I could get it. But maybe a certain amount of physics in my background says that any machine that has a great deal of friction in it tends to dissipate a lot of energy needlessly. If we could simply keep track for a while of how many medicaid/medicare patients we provide service for, and then take that money off the top and never put it in medicaid in the first place, so we do not go through all the steps of billing and all the extra salaries it takes to achieve the billing, and just earmark it in the beginning, we would not lose as much to the middleman.

Senator MELCHER. Well, what you started to say about a claim against medicaid going to the area office, do you computerize those at the area office?

Dr. HAUXWELL. Yes.

Mr. DANIELSON. Yes. We are one of the three areas that has that capability.

Senator MELCHER. Properly programed on the computer, it would come directly credited back to you and would be in your accounts held there in the area office, would it not?

Mr. DANIELSON. Yes; that could be done very easily.

Senator MELCHER. I mean, any money allotted to you is in the account. That is the way it works, isn't it? To be credited back to that account? I think it could work. And we will have to present an amendment to this bill to say exactly how we want it to work. Because apparently, it is not clear enough yet as a statute that has been put into operation.

How long have you been down there in Lame Deer?

Dr. HAUXWELL. Six years.

Senator MELCHER. During that 6 years, have your needs been looked at first?

Dr. HAUXWELL. By whom?

Senator MELCHER. By IHS, by your superiors.

Dr. HAUXWELL. Well, I am not sure exactly how to answer that. There are some people who look at various needs. And the more remote from our site you get, the less tendency there is to look at our needs first, certainly, because the higher up you get, the more different units needs have to be considered. And, I suppose, the greater tendency is to consider the organizational needs as opposed to the impact on a given patient.

Senator MELCHER. This is a long recognized problem.

Dr. HAUXWELL. I think it is inherent in the bureaucracy.

Senator MELCHER. Yes; it is inherent in the bureaucracy. Whoever is in health care is supposed to be above the normal pitfalls of bureaucracy, to avoid them at that level of professionalism.

This is a problem that Dr. Johnson related many times in discussions we had. This is a problem that Dr. Rhoades fully recognizes—at least he tells us he does—and one of the challenges he faces as director.

So we are going to be interested in how this can be reversed and where your needs there on the reservation can be examined as a priority means. And then those above it can be given less priority in order to meet your needs. It is a real challenge.

Dr. HAUXWELL. That would tickle my fancy.

Senator MELCHER. Well, it would everybody, I know. But it is a real challenge to everybody else. And until we meet that challenge, we are ready to try to cope with it. We are not really doing what we all agree is a main problem of IHS, and that is, meet those needs. And then to structure all the layers above in order to accommodate your needs.

Dr. HAUXWELL. My perception is that over the past year or so, our channels of communication with the area office have improved. That is, that it is a little easier to approach someone in the area and say, "I am having a problem with this. Is there anything you can do about it?"

There was a time when not all personnel in the area were as accessible as they seem to be getting now. That is not to say that sometimes decisions are made—or potential decisions are made in great detail—

before some of the information, in my opinion, which might be pretty useful in formulating a decision was even solicited.

Did that make any sense? Sometimes it seems to me like there's a reversal in the order of the process. Rather than saying, "We've got to do something about this, what would we need to know from you guys to do it." Sometimes a fairly detailed formula is worked out, and then we are informed of that. And they say, "How is that going to affect you?" But that is probably unavoidable sometimes.

Senator MELCHER. Do you think there is a shift, though?

Dr. HAUXWELL. Oh, definitely. I have been very pleased in recent months. The tolerance of those of us in the field who gripe and tell horror stories has increased, I think we are being listened to better now.

Senator MELCHER. I am glad to hear that.

Dr. HAUXWELL. You can give me that $5,000.

Dr. COPP. If you would indulge with me for a minute, I would like to expand a little on that, because I think it is important to understand that we have become sensitive to some of these problems in the area office, and some of the things that have been done in recent months have been to adapt to those needs.

Specifically, what we are attempting to do is look at the health delivery system at the health service. Independently and individually, we are doing it with a group that combines area office staff, service unit staff, and tribal representatives. We get them together and have them intensively work through the process of looking at the whole package; what the statistics are, the facts, the funding, the whole business, and come up with specific recommendations for the area director in terms of, "This is where we should be going here in this unit."

And as we do that, we are getting very positive kinds of information back. We are getting some creative kinds of ideas from the combined group, and it puts them, in essence, on the same track, talking to each other and coming to some common kinds of conclusions.

So it has been a very positive process. So far we have been able to do that with only three of the service units, but we are going to extend that to the other service units as well.

A lot more interaction appeared and I think, trust and understanding is developing from it.

Senator MELCHER. Good. I am glad to hear that. We have one final point, and that is the Montana Indian Health Board. It says that Mr. Thomas incurred some bills. I think some of those bills might have been incurred even before Mr. Thomas was there.

But why isn't IHS assisting the Montana Indian Health Board?

Mr. DANIELSON. I have had some informal discussions with staff and members of the board in two areas. The first area is that of the authorization or the identification of a spokesperson for the individual tribal groups which, for the three resolutions was, for the most part, the five of us.

So I have had indicated to me that what we really need as an organization is to know in what areas the tribe is delegating the responsibility, giving the spokesmanship to the board to act on their behalf. I have asked them if they would take that step and help us to identify the areas that we should be trying to deal with.

The second point that I have discussed with some of the tribal governments also has to do with the limited amount of funding that we have available for that kind of activity in the area. With the type of funding that we are using for that, which is tribal management dollars, it means that there has to be some adjustments out of the overall category of funding in order to cover that.

I simply want to point out that we need to be aware when we talk about that. So we are not refusing to be able to go to the board. But, since the original starting board, they have had so many things change, with regard to our relationship with the tribal government and with the whole process of community involvement, that we all should be asked to reassess our relationship with each other, and establish the network based on current relationships.

Senator MELCHER. Well, that does not get to the point, though, that Mr. Thomas was an employee of the Indian Health Service, and it has been alleged by the board today, and previous to that, that he incurred and authorized the expenditure of funds that have not been paid.

Mr. DANIELSON. There are two points that I can make. And I am not talking of the total bits of information on the subject.

The first point is that there is a lack of documentation, in general, which specifies, first of all, what it constituted. Where was the authorizing source? That is one problem.

The second point is that in the process of assigning an employee to an organization, that person in effect becomes a part of that organization's operation of command. It is a process that becomes very involved in terms of the parent organization and the organization that receives that employee, in terms of working out the responsibilities.

Senator MELCHER. What is his job classification right now?

Mr. DANIELSON. He is a special assistant to myself, working on special assignments.

I have him working in two areas right now. One area has to do with a project involving team building, which is dealing with a bunch of the issues that they point out have presented problems in communications, working relationships and that sort of thing.

The second part of that has to do with the development of the performance standards for the Billings area, which is the directors and area office staff, and doing the monitoring in the recordkeeping portion of it.

Senator MELCHER. Well, I would like to see this cleared up. Could you audit both sides of the allegations surrounding the Montana Indian health board, and also what each tribe thinks they have coming?

I presume that most of this deals with meetings that were called, where they sent people. Therefore, there were charges for traveling, transportation costs, per diem. Whatever is justified in the way of IHS payments being made is a matter to be rectified. Whatever obligation there is, I would like it taken care of. I would like to be advised what that obligation is and what the arrangements are to take care of it.

Mr. DANIELSON. I will pursue that.

Senator MELCHER. Good. Thank you all very much. I appreciate your comments and your candid discussion. We will be pursuing several items in connection with that.

The hearing is adjourned.

[Whereupon, at 3:05 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL RECEIVED FOR THE RECORD

Billings American Indian Council

105 North 25th Street
Billings, Montana 59101
(406) 657-6056

RECEIVED JUL 1 8 1983

July 12, 1983

Honorable Senator John Melcher, Chairman
Senate Select Committee on Indian Affairs
Federal Building
315 N. 26th St.
Billings, Montana 59101

Dear Senator Melcher:

Enclosed is written testimony (original and ten copies) for presentation to the Senate Select Committee on Indian Affairs; specifically regarding reauthorization of Public Law 94-437, Title V, Indian Health Care Improvement Act.

Please share the views and comments with members of the committee. Your favorable consideration of the attached comments and recommendations is appreciated.

Sincerely,

Sybil L. Sangrey

Sybil L. Sangrey
Employment Counselor

SLS/sp
Enclosure

PREPARED TESTIMONY OF THE BILLINGS AMERICAN INDIAN COUNCIL
SUBMITTED BY SYBIL SANGREY, EMPLOYMENT COUNSELOR

Mr. Chairman and Committee Members,

The Billings American Indian Council (henceforth Bilaminco) with an Urban Indian Health Program would like to thank this committee for the opportunity to submit written testimony and comment on the reauthorization of Title V, Urban Indian Health, Public Law 94-437, Indian Health Care Improvement Act.

The Billings American Indian Council believes Title V, Urban Indian Health is and will be the only mechanism to make health care accessible to Indian people in urban areas. Bilaminco urges this committee to fully support the efforts of all parties concerned in getting Public Law 94-437, Indian Health Care Improvement Act, reauthorized.

If Title V does not again become authorized, there will be a great negative impact on the health status of Indian people in urban areas. In addition, the impact will be felt by private providers and will create major medical needs for the Indian people living in urban areas. Indian people who do not have access to health care will be using emergency rooms or prolonging their illness and putting off treatment until the illness becomes life threatening, they become hospitalized, or require major medical attention. Many of the Indian patients cannot afford to pay for the emergency visits, hospitalization, or major medical care. Thus it puts a financial burden in both the patient and private providers. Urban Indian Health Centers nation wide provide efficient medical attention in a cost effective manner. The cost to private providers and local

hospitals will be far greater than it would for the Federal Government to provide medical care to Indian people in Urban areas. The early intervention and prevention services offered by the Urban Indian Health Centers have reduced or in some cases, eliminated the need for expensive forms of health needs, such as hospitalization, emergency room visits, and major care needs.

Bilaminco operates a cost effective, highly productive, and unduplicated health care delivery system, according to an evaluation of the Bilaminco Health Program and Outpatient Clinic conducted in 1981 by a private firm. Bilaminco is still maintaining a cost-effective operation, e.g., in Fiscal Year 1982, the cost per visit to the Indian Clinic physicial was $8.64. If each of the Indian Clinic patient visits had to be seen by a private physician, it would have cost $73,656.00, as compared to the $26,520.00 paid to the Indian clinic physician, a total difference of $47,136.00. This is a 278% savings! Bilaminco is not taking or duplicating business from private medical providers, because the majority of Indian patients utilizing Bilaminco health services cannot afford to pay for their health care. Despite the limited funding from the Indian Health Service, Bilaminco improved the provision of preventive health services. The immunization levels for Indian children climbed over 90%, many pregnant women are now receiving medical care in the first trimester instead of at delivery, and in general, the incidence of emergency room visits and hospitalization has been reduced through intervention.

By reauthorizing Title V, Urban Indian Health, Public Law 94-437, at an adequate funding level, future health needs of the Billings American Indian community will decrease. Presently, there is a great need to continue and upgrade the health care delivery system for the Billings Indian community. Every effort is being made to become a self-sufficient and independent health care providor, but your support is needed to maintain and meet the goals to attain that independence. Seven (7) months into Fiscal Year 1983, patient visits without medical coverage have risen to a shocking 91.47%, as computed to 82.77% in Fiscal Year 1982. The sudden rise in patients without medical coverage is due to governmental budget cutbacks, rising unemployment, and eligibility criteria changes in medicaid, medicare, Indian Health Service, and other health agencies. The migration of Indians from reservations is ever increasing. Lack of housing, high unemployment, and hopelessness for a stable future is driving Indian people from reservations to seek a new life in urban areas. This is indicated by the New Patients Per Month count. For example, since February, 1979 to April, 1983, the Indian Clinic alone averaged forty seven (47) New Patients Per Month. Additional funding is needed to serve the patient load effectively, and to help relieve the strain on both the patients and the Health Program Clinic.

Indian people nationwide encounter problems obtaining adequate health care from any source. Many Indian people in Billings are not exempt from the obstacles of obtaining health care. With the present economic picture, limited job skills, lack of

experience, education, unfamiliarity with the city health care system, and cultural barriers, Indian people maintain a low level of health care maintenance in the Billings area. Due to financial constraints, most Indian people must concern themselves with basic necessities such as food, shelter, and clothing, resulting in the inability to pay the high costs for medical care from private providers. Indian people find it difficult to deal with city, county, and state agencies that are insensitive to their needs and problems. Indian people seeking health services from these agencies find that the agencies are reluctant and, in some cases, refusing to assume the responsibility for providing health care to Indian people, viewing it as the Federal Government's responsibility. This puts the Indian people in a "Catch 22" situation which creates additional obstacles to receiving health care. Because of the problems encountered with non-Indian oriented services and the failure of the Federal Government to fully meets its trust responsibility to Indians, many Indian people have gone without medical care.

In maintaining statistical profiles of individual Indian patients registered into the Bilaminco Health Program and Outpatient Clinic, data reveals that 85% of the patients do not have health insurance. The patient's monthly income decreased in 1982 by $13.96. In 1981, the patients' average monthly income was $353.93. This computes to $4,247.16 annually, as compared to $19,908.00 per year for the median American family income according to the 1980 census.

There have been many beneficial results with the establishment of the Billings American Indian Council Health Program and Outpatient Clinic. The Indian patient can receive primary medical care in which 90% of all medical needs can be addressed at the Indian Clinic. The Bilaminco Health Program assists patients with other needs that cannot be managed at the clinic by obtaining care through referrals, client transportation, and networking with other health providers. Without the existence and advocacy of the Bilaminco Health Program and Outpatient Clinic, the Indian population in need of medical care would surely fall through the cracks of the City, County, State, and Federal health care sytems and the Indian Health Service. Bilaminco Health Program and Indian Clinic have developed active linkages and networking with other health and social service providers throughout the greater Billings Area.

The Billings American Indian Council recommends the following items for the reauthorization of Title V, P.L. 94-437, Indian Health Care Improvement Act:

- an increased base funding at $25 million in Fiscal Year 1985 and this be introduced for a seven (7) year period.
- conduct an on-going collection and analysis of a standard data reporting system.
- provide Congress with a progress report on the 3rd, 5th, and 7th years.
- change the service priority of the Indian Health Care Improvement Act to primary health care services.

- reallocate the funding dollars according to the users rate of penetration of urban Indian population.
- increase funding dollars to provide facility renovation.
- increase funding level to provide quality medical and dental equipment and supplies.
- increase funding appropriation to provide hospital and extended care to the medically indigent Indian patient who have no other source of coverage.
- continue the appropriation of funding to the Indian Health Care Improvement Act and amendments there of, until the health status of the American Indian is equal to the average American population.

There are approximately five thousand (5,000) Indian people residing in Billings, Montana. The majority of these people do not have health insurance, the financial means, nor the resources available to them to obtain adequate medical care from private providers in the city. The reauthorization of Title V will insure these Indian people the opportunity to seek medical attention they deserve. Prior to establishment of the Bilaminco Health Program and Outpatient Clinic, the majority of Indian people in need of medical care simply went without treatment. Because of inaccessibility and financial burdens, Indian people surviving on limited resources held little priority for health problems unless they become life-threatening. The Indian people do have interest in their health and maintaining a good health status. Title V, P.L.

94-437 has enabled the Indian people in Billings, Montana, to obtain medical attention and practice preventive health care. Although there are still unmet health needs of Indian people, with your efforts and support, Indian people can continue to have the opportunity of obtaining the medical attention they need. Thank you for your kind and favorable consideration in addressing the needs of the Billings Indian community. We trust that this committee will act with all consideration of their constituents to see that Title V, Public Law 94-437, Indian Health Care Improvement Act becomes reauthorized.

May, 31, 1983

To: The honarable Chairperson and distinquished committee members.

RE: Appropriation of funds and continuation of the INMED program and Indian Health Service Scholarships.

Please allow this letter as testimony of the effectiveness, the worth and the continued need of the INMED program.

I was an early recipient of the INMED services, including: scholarship, ACE (acdemically controlled environment), tutorial, counseling, cultural enrichment, and, of course, MUCH encouragement to pursue a career in the medical field.

I can honestly say that I needed and utilized each component of the program. When I started I was married and had three children; now we have five children and I am a second year Resident physician in Family Practice.

INMED helped me build a base of educational knowledge and confidence that enabled me to enter and complete medical school; they continued that support while I was in school. Incidentally, I graduated in the upper one-fourth of my class. and received two awards for scholastic achievement.

Many of INMEDS graduates are serving Indian people across the nation; others will certainly follow.

With this information I ask that this distinquished committee recomment continued support of the INMED program and the Indian Health Service scholarship program.

Sincerely Yours

Charles A. LaRoque, M.D.

Enrolled member of the Sisseton-Whapeton Sioux Tribe of Sisseton, South Dakota

KALISPELL REGIONAL HOSPITAL
KALISPELL MONTANA 59901
PH: 755-5111

RECEIVED JUL 5 1983

June 29, 1983

Senator John Melcher
1123 Dirksen Office Building
Washington, D. C. 20510

Dear Senator Melcher:

The purpose of this writing is to express our concerns regarding the implementation of competitive bidding for contract health care on the Flathead Indian Reservation, Lake County, Montana, by the Indian Health Service.

Kalispell Regional Hospital is currently associated with St. Luke Community Hospital and Nursing Home, Ronan, Montana and Mission Valley Community Hospital, St. Ignatius, Montana under an "Inter-Hospital Cooperation Agreement".

Competitive bidding for contract healthcare has been an on-again off-again issue with the Indian Health Service and the health care providers in Lake County for the past year. During that time, concerted efforts were made by local tribal health officials and health care providers in exploring alternatives to competitive bidding which would address the problems of uncertain levels of funding for Indian Health Care services while attempting to gradually improve the health benefit program over that which is currently available. An adaption of the Preferred Provider Concept (PPO) was identified as a possible workable alternative.

On May 25, 1983, various hospital Administrators from Lake, Missoula, Flathead and Sanders Counties were invited to attend a meeting with a "Contract Care Review Team" from the Public Health Service District Office in Billings. The review team also met with various local physicians. The health care providers were advised as follows:

1. Competitive bidding for Indian Health Service Contract Health Care will become effective October 1, 1983.

2. Contracts will be awarded to two Missoula Hospitals based on specialty services provided at each respective facility.

3. A contract would automatically be awarded to Kalispell Regional Hospital.

4. Physician services would not come under competitive bidding at this time.

5. Clark Fork Valley Hospital in Sanders County will automatically receive a contract.

6. Unless the three hospitals in Lake County were able to work out a split in services for which three contracts could be awarded (i.e., one hospital does all surgery, another does obstetrics, etc.), there would be a very strong probability that only two of the three hospitals would be awarded contracts.

The problems which could result from competitive bidding in Lake County, if the program were permitted to be implemented as suggested by the "Contract Care Review Team" are enormous and our concerns are expressed as follows:

1. If any of the three hospitals were to lose its' share of Public Health Service volumn, the financial impact would be such that the facility would either close entirely or would necessarily have to alter services provided to the degree that patients in the effected community would be forced to travel to another community for a portion of currently available primary hospital services. The closure of a hospital or a substantial curtailment of services by an effected hospital will greatly impact the economy of the community through a substantial loss of jobs and the forced routing of patients out of the community for primary hospital services.

2. The stability of the physician population will be threatened since they will be forced to hospitalize their patients out of the community or refer patients to other physicians with privileges in a contracted hospital. Further, if a hospital is economically forced to curtail its' services, the physicians in the community may not have the opportunity to locally provide certain hospital procedures for which they are trained and fully qualified to perform. It is our experience that when physician practices are curtailed, they are very likely to relocate.

3. Each of the three hospitals in Lake County furnish primary, acute inpatient and outpatient services to a substantial number of Public Health Service beneficiaries. The "Contract Review Team" has suggested that only two of the three hospitals will receive contracts and that the hospital in Ronan would probably not be considered regardless of bid.

   It is our opinion that decisions have already been made as to the outcome of competitive bidding.

4. Competitive bidding will not, in our opinion, address the issues of limited funding, access to health services, and improved quality health care for the Indian people.

   a. The contract review team stated that the cost of health care in Lake County is the least expensive in the Billings Public Health Service district.

   b. The Indian people on the Flathead Reservation currently have a health care program which is less than that provided to the poor under Medicaid. Hospitalization is restricted to emergency only. This means that unless life or limb is threatened, hospitalizations cannot occur. Conditions which currently exist and could be treated in the normal course less expensively have to wait until they are an emergency and have to be treated at a substantially higher cost. In no way under competitive bidding can this deplorable situation be corrected.

   c. If contracts are awarded to only certain hospitals, patient freedom of choice and access to health care no longer exists.

5. Physicians not being subjected to the competitive bidding process would, in our opinion, defeat the purpose of competitive bidding which is cost containment. Physicians control hospital admission, diagnostic and therapeutic procedures during the hospital stay and the discharge of patients. It is an absolute mistake not to include all health care providers in the cost containment process rather than expect hospitals to control that which is not within their power to control.

6. The Indian population in Lake County is substantially less than the non-Indian population. The effect of competitive bidding as outlined by the "Contract Care Review Team" will be to drastically alter the health care delivery system for the majority of the population with such changes being dictated by the lesser population group.

   Competitive bidding, in our opinion, will not solve the issue of cost containment nor will it provide for the improvement of the quality of life for the Indian population. It will, however, create tremendous problems of accessibility to primary health care, may create an exodus of physicians and may result in a negative economic impact within Lake County.

If after review of the information contained in this letter, it is felt that this issue of competitive bidding and the implications of its implementation require your attention, we would appreciate your involvement.

Sincerely,

GEORGE W. CLARK
President

GWC:rp

KALISPELL REGIONAL HOSPITAL
KALISPELL MONTANA 59901
PH: 756-6111

July 5, 1983

Senator John Melcher
1016 Federal Building
Billings, Montana 59101

Subject: Testimony - Select Committee
on Indian Affairs

Proposed implementation of competitive
bidding for contract health care services -
Flathead Indian Reservation

Dear Senator Melcher:

This text is provided as testimony in opposition to the Indian Health Service planned implementation of competitive bidding for Contract Health Care on the Flathead Indian Reservation.

Kalispell Regional Hospital is currently associated with St. Luke Community Hospital and Nursing Home, Ronan, Montana, and Mission Valley Community Hospital, St. Ignatius, Montana under an "Inter-Hospital Cooperation Agreement."

The issue of competitive bidding for contract health care has been on the backs of the Confederated Kootenai - Salish Tribe, and the physicians and hospitals in Lake County for the past year and a half.

It has become increasingly clear that the process, desired outcome, and potential impacts of contract health care competitive bidding have not been thought out by the programs proponents.

Local health care providers and tribal health officials have met with representatives of the Billings District office on numerous occasions and have been subjected to a myriad of different bidding and implementation methodologies as well as numerous effective dates. Providers were told in the beginning that all contract care providers would be required to bid. Later it was just physicians and hospitals. On May 25, 1983, at a meeting in St. Ignatius, the providers in attendance were advised that physicians would not be required to bid. Then on June 28, 1983, a district office representative advised that physicians would come under competitive bidding. It has been suggested by these

representatives that one desired outcome of competitive bidding would be to reduce the number of contracting hospitals. Such a plan may have merit in urban and metropolitan areas where hospitals are situated relatively close together, and population bases are large, however, the impact of such a plan on a small hospital in a small rural community would be absolutely devastating.

If any of the three hospitals were to lose its' share of Public Health Service volume, the financial impact would be such that the facility would either close or would necessarily have to alter its' services to the degree that patients in the effected community would be forced to travel to another community for a portion of currently available primary hospital services. The closure of a hospital or a substantial curtailment of services will greatly impact the economy of the effected community through a loss of jobs and the forced routing of patients out of the community.

The stability of the physician population will be threatened since they will be forced to hospitalize their patients out of the community or refer to other physicians with privileges in a contracted hospital. Further, if a hospital is economically forced to curtail its' services, the physician in the community may not have the opportunity to locally provide certain hospital procedures for which they are trained and fully qualified to perform. When physician practices are curtailed and income is threatened they are very likely to relocate.

Competitive bidding will not, in our opinion, address the issues of limited funding, access to health services, and improved quality of care for the Indian people. The Indian people on the Flathead Reservation currently have a health program which is less than that provided to the poor under Medicaid. Hospitalization is restricted to emergency only. This means that unless life or limb is threatened, hospitalization cannot occur. Conditions which currently exist and could be treated in the normal course less expensively must wait until they are an emergency and must be treated at a substantially higher cost.

Requests for discounts through the competitive bidding process is a temporary measure at best and offers no assurance that a financial relief will be realized. The problems of utilization control and extremely limited health coverage for the Indian people still exist.

It is our opinion that a concerted effort must be made between health care providers, Indian Health Service and the local tribal council in seeking a viable alternative which provides a reasonable assurance of cost reduction. Such a system must provide for utilization control and must seek to gradually improve the level of health care benefits available to the Indian people. During the past year, local health care providers and tribal health officials identified a system which not only attempts to address all the major considerations but, provides for on-going, active participation by the health care providers and the Kootenai-Salish tribe in achieving the desired goals. Such a system is an adaption of the Preferred Provider Organization (P.P.O.) concept.

Unlike competitive bidding which seeks a discount while providing no incentive for participation by the provider and no incentive for the consumer to utilize health care properly, the Preferred Provider concept seeks to accomplish the following:

1. Providers provide a negotiated discount for services in return for a rapid turn around of claims payment with guaranteed no bad debt on pre-approved coverage of eligible beneficiaries.

2. Implements an on-going utilization review process which looks at both the health care provider and the consumer.

3. Attempts to utilize appropriate providers for needed health care. Primary physicians when warranted and specialty physicians as appropriate.

4. Attempts to utilize local providers as appropriate, thus a potential for increased volume which warrants discounts and which serves to provide for greater utilization control exists.

5. The P.P.O. concept attempts to look at the overall cost of health care and utilization in an effort to roll forward any savings realized in the previous year, forward to promote better health care coverage for the Indian people in subsequent years.

Although problems exist in implementing such a program, mainly between the tribe and Indian Health Service, we feel that the potential benefits far outweigh the unknowns of competitive bidding and should be explored in greater depth, before competitive bidding is adopted as a cure-all solution.

Sincerely,

GEORGE W. CLARK
President

GWC:rp
cc: Greg DuMontier
Executive Director
Tribal Health Council

THE NAVAJO NATION
JUDICIAL BRANCH

JUDICIAL BRANCH OF NAVAJO NATION
P. O. BOX 447
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PHONE (602) 871-4137

July 19, 1983

RECEIVED JUL 25 1983

Senator John Melcher
United States Senate
253 Russell Senate Office Building
Washington, D.C. 20510

RE: Indian Health Services

Dear Senator Melcher:

When I visited Montana recently to touch base with home I was pleased to read about the hearing you conducted on Indian health problems. Because I have had a great deal of experience with Indian health in Montana and here I am writing to give you some information about some of the problems I have seen.

We know that the Indian Health Service is in financial trouble because of health care demands, and we know that obligations for contract services take a large part of the IHS budget. However I contend that a good deal of money is wasted because of the inability of the IHS to comply with its own regulations and policies. The IHS Manual has long provided for (1) payment for health services in accordance with the income of individual Indians and (2) recoupment for the value of medical services when there is an individual personal injury recovery. I don't know what the IHS is doing about sliding scale payments, but I do know that my experience with the IHS service unit at Rocky Boy's Reservation has been that they have utterly no understanding of how to help recoup funds in personal injury situations. On one occasion I wrote the service unit for a dollar figure on services to my client, based upon her medical records, only to receive a letter back from the service unit director that "services to Indians are free" and he didn't understand what I was talking about. In other words, the IHS has not had to deal with cost accounting in making certain that health care expenses are paid back when the law provides for it, and these procedures will have to be tightened.

There are a number of problems in dealing with emergency contract treatment. Although IHS regulations provide that emergency contract services can be provided on the basis of either a phone call authorization or an authorization obtained immediately following emergency services, record keeping and

authorization procedures are sloppy. I know of one case where a man was treated at Northern Montana Hospital in Havre on the basis of an emergency telephonic approval but afterward the service unit has refused to authorize payment for emergency services. The result is that the individual Indian is being hounded by Northern Montana Hospital for the large cost of his treatment, and the IHS is evading the obligation it incurred. The individual will not be harmed because of the fact he cannot be reached by a court judgment for services, but emergency treatment for Indians is jeopardized by the failure of the IHS to follow simple administrative procedures. This of course creates the resentment of state and private health care agencies which you heard in Billings.

The "on or near" reservation eligibility standard has been a problem in the past, and I suggest to you that the Indian Self-Determination Act has created a loophole which is hurting people such as the Little Shell Chippewa Indians of Montana. People are usually sent to the tribe where they are enrolled, and contracted IHS services are provided to enrolled members only. What is happening to Indians who are eligible for services under the Synder Act but who are not members of "recognized" tribes? With the failure of Congress to adequately fund urban Indian health programs, many off-reservation Indians are being hurt.

The IHS has a bad reputation in Indian Country. Time and time again I have heard Indians from Montana dn the Navajo area complain of bureaucratic delay, confusion and open medical malpractice. I suggest that while there is a legal structure in place for the IHS that administrative confusion and a lack of understanding of how to responsibily administer health services is causing waste and mistrust of the IHS. I don't know that the solution is legislative as much as it is one of making certain that the IHS learns proper administrative procedures.

Montana and other state agencies have the right to a clear understanding of their responsibilities to Indians and the right to recieve what they are due from the IHS under federal health programs. Your efforts to clarify this existing mess are important, and if I can provide any information for your work I would be glad to help.

James W. Zion, Solicitor
to the Courts of the Navajo Nation

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